



Department of Health and Mental Hygiene

Mental Hygiene Administration
IMPLEMENTATION REPORT for the
FY 2011 STATE MENTAL HEALTH
PLAN

A CONSUMER – ORIENTED SYSTEM

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“The services and facilities of the Maryland Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex, or national origin and applies to the provisions of employment and granting of advantages, privileges, and accommodations.”

“The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.”

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STATE OF MARYLAND MENTAL HYGIENE ADMINISTRATION

MISSION

The Department of Health and Mental Hygiene's Office of Behavioral Health and Disabilities will develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions and developmental disabilities. The Mental Hygiene Administration will, through publicly funded services and supports, promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders.

THE VISION

The Vision of our public mental health system is drawn from fundamental core commitments:

- Coordinated, quality system of care
- A full range of services available
- Seamless linkages to services for the consumer delivered through a system of integrated care
- Recognition that co-occurring and co-morbid conditions are the norm
- Focus on treatment, behavioral health, support, recovery, and resilience
- Services developed in collaboration with culturally competent stakeholders in an environment that is culturally sensitive
- Improved health, wellness, and quality of life for consumers

VALUES

The values underpinning this system are:

(1) BASIC PERSONAL RIGHTS

Persons with psychiatric disabilities have the same rights and obligations as other citizens of the state. Consumers have the right to choice, to retain the fullest possible control over their own lives, and to have opportunities to be involved in their communities.

(2) RESPONSIVE SYSTEM

The Public Mental Health System must be responsive to the people it serves, coherently organized, and accessible to those individuals needing mental health care. Information must be readily available for individuals to enter and proceed through the system in a more appropriate and timely manner. The hospitals are one part of the community-based mental health system. The Public Mental Health System must collaborate with other public and private human health service systems in order to allow for continuity of care and facilitate support with all activities of life.

(3) EMPOWERMENT

Consumers, families, and advocates will be involved in decision-making processes, individually at the treatment level and collectively in the planning and operational aspects of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Relevant programs and services that recognize varying cultural, ethnic, and racial needs are imperative.

(4) *FAMILY AND COMMUNITY SUPPORT*

We must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. We will strive to provide services to persons within their communities with the availability of natural/family supports.

(5) *LEAST RESTRICTIVE SETTING*

An array of services will be available throughout the state to meet a variety of consumer needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.

(6) *WORKING COLLABORATIVELY*

Collaborations with other agencies at the state and local level will be fostered so support to consumers is inclusive of all activities of life. This will promote a consistently appropriate level of mental health services.

(7) *EFFECTIVE MANAGEMENT AND ACCOUNTABILITY*

Accountability is essential to consistently provide an adequate level of mental health services. Essential management functions include monitoring and self-evaluation, responding rapidly to identified weaknesses in the system, adapting to changing needs, and improving technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.

(8) *LOCAL GOVERNANCE*

Local management of resources, resulting from the implementation of Core Service Agencies, will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources with needs, and increase economic efficiency due to the closer proximity of the service delivery level.

(9) *STAFF RESOURCES*

The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.

(10) *COMMUNITY EDUCATION*

Early identification and prevention activities for risk groups of all ages, public education, and efforts that support families and communities must be incorporated into our service system. Increased acceptance and support for mental health services come from increased awareness and understanding of psychiatric disorders and treatment options.

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These Mental Hygiene Administration (MHA) goals, objectives, and strategies are a result of the collaborative efforts related to the implementation of the federal Mental Health Transformation State Incentive Grant (MHT-SIG), existing interagency cooperation, and public and private partnerships. These alliances have been strengthened and new partnerships formed to further build upon the infrastructure, coordinate care, and improve service systems. Mental health transformation efforts and activities have fostered the implementation of increased opportunities for public education; awareness; training of consumer, families, and mental health professionals; support of employment; self-directed care; and affordable housing options. Advancement will be effectively amplified through the support of Web-based technology that increases awareness and linkages to services; promotes wellness, prevention, and diversion activities; and enhances efforts in cultural competency, evidence-based and promising practices. These advancements are infused throughout the MHA State Mental Health Plan for children, adolescents, and adults. Recognizing the current fiscal environment, MHA strategies involve effective and efficient collaborations to identify and support sustainability of transformation gains that promote recovery, resiliency, and health-care reform.

In previous years, to foster the implementation of a consumer-driven recovery and resilience oriented system, MHA followed Substance Abuse and Mental Health Services Administration's (SAMHSA's) lead in adopting the goals and recommendations outlined in the 2003 New Freedom Commission Report: *Achieving the Promise: Transforming Mental Health Care in America*. To continue improvement in the delivery of prevention, treatment and recovery support services, SAMHSA has identified 10 Strategic Initiatives to focus the Agency's efforts. This year MHA has organized its FY 2011 plan activities based on these initiatives.

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GOAL I. INCREASE PUBLIC AWARENESS AND SUPPORT FOR IMPROVED HEALTH AND WELLNESS.

Objective 1.1. The Mental Hygiene Administration (MHA), in collaboration with the Core Service Agencies (CSAs), will continue to work with the mental health community to initiate educational activities and disseminate, to the general public, current information related to psychiatric disorders, prevention mechanisms, treatment services, and supports.

(1-1A)

MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Mental Health Transformation Office (MHTO), the Missouri Department of Mental Health, and the National Council for Community Behavioral Health, will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland.

Indicators:

- Mental Health First Aid Participant Manual and Teaching Notes (adapted for adults) published, distributed, and promoted
- Work with the Mental Health Association of Maryland (MHAMD) and national partners continued to develop a MHFA USA Youth Manual and teaching notes
- Web-based MHFA USA training developed to increase access and availability for the general public
- Trainings promoted and implemented statewide

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Deputy Director, Community Services and Managed Care; Cynthia Petion and Carole Frank, MHA Office of Planning, Evaluation, and Training; DHMH; CSAs; Mental Health Association of Maryland (MHAMD); Maryland Coalition of Families for Children's Mental Health; On Our Own of Maryland; Missouri Department of Mental Health; the National Council for Community Behavioral Health; Mental Health and Criminal Justice Partnership; Maryland Police and Correctional Training Commission; other mental health advocacy groups

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director, Daryl Plevy, MHA Deputy Director, Community Services and Managed Care

FY 2011 activities and status as of 6/30/2011 (end-year report):

Mental Health First Aid (MHFA), a 12-hour course that teaches lay people methods of assisting someone who may be in the early stages of developing a mental health problem or in a mental health crisis situation, continued to expand in FY 2011. In FY 2011, 30 MHFA trainings were held and more than 600 Marylanders were certified in MHFA. The groups who have participated in MHFA trainings include criminal justice staff, administrative law judges, human resources professionals, Core Service Agencies, behavioral health organizations, and students, faculty, and staff at a number of colleges and universities across the state. The total number of Maryland residents trained in MHFA now exceeds 2,500 people. It is expected that trainings in Maryland will continue beyond FY 2011, sustained through course fees, sales of manuals, and grants. A Web-based MHFA USA training has been developed to increase access and availability for the general public.

Working closely with its partners, the Missouri Department of Mental Health and the National Council for Community Behavioral Healthcare, as well as Maryland advocacy organizations, more than 38,000 copies of the manuals and 900 instructor teaching kits have been produced and distributed nationally. Curriculum supplements for workplace, law enforcement, military/veterans, primary care, assisted and aging living, faith communities, and higher education have been developed and are being piloted. A MHFA USA Youth Manual and teaching notes are in the process of being developed for future dissemination.

Maryland has been a national leader in adapting MHFA for American audiences. (The original MHFA program was developed in Australia). Maryland's leadership has resulted in expressions of interest in MHFA from a number of other states. In January 2011, Mental Health First Aid has been featured on prominent radio and television programs in Maryland and Washington, DC. An article was submitted to *Medscape*, (an online reference that provides access to journal articles that impact the health care community) highlighting Maryland's work on MHFA USA both in the state and nationally. On a national level, a series of podcasts were taped that will run in the fall 2011 promoting MHFA in the workplace.

Strategy Accomplishment:

This strategy was achieved.

(1-1B)

MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.

Indicators: Activities include:

- Maryland Coalition of Families for Children's Mental Health's (MCF) and Mental Health Association of Maryland's (MHAMD's) Children's Mental Health Awareness Campaign – "Children's Mental Health Matters"; number of public service announcements aired, volume of literature disseminated, and other outreach activities implemented
- National Alliance on Mental Illness (NAMI MD) – NAMI WALK, Family to Family, and other education programs
- On Our Own Maryland, Inc. (OOOMD) – Anti-Stigma Project workshops
- Promotion and usage of Network of Care
- MHAMD outreach campaign for older adults
- DHMH statewide outreach media campaign
- Wellness and Recovery Centers' outreach efforts

Involved Parties: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services; James Chambers, MHA Office of Adult Services; Cynthia Petion, MHA Office of Planning, Evaluation, and Training; MHA Office of Consumer Affairs; appropriate MHA staff; CSAs; Maryland Coalition of Families for Children's Mental Health; MHAMD; NAMI MD; OOOMD; Wellness and Recovery Centers; community providers

MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services; and Cynthia Petion, MHA Office of Planning, Evaluation, and Training

FY 2011 activities and status as of 6/30/2011 (end-year report):

Maryland Coalition of Families for Children's Mental Health's (MCF) and Mental Health Association of Maryland's (MHAMD's) *Children's Mental Health Matters* awareness campaign

This year MCF and MHAMD continued the partnership to promote the successfully received *Children's Mental Health Matters* awareness campaign. This significant social marketing effort is designed to build a network of information and support for families across Maryland and raise awareness of children's mental health. The two organizations have initiated a "Call to Action" to all stakeholders, requesting their participation in and support of this project. More than 80 professional associations, advocacy organizations and provider associations have signed on as Campaign partners. By establishing partnerships with stakeholders and other concerned organizations, recognition of Children's Mental Health Awareness Week has been increased and enhanced.

In the spring of 2011, the Campaign conducted a statewide effort with advertising on 40 Maryland Transit Authority (MTA) buses to alert riders to the symptoms of mental health problems in children and adolescents. Campaign kits/tools include awareness ribbons,

bracelets, posters, window clings, brochures, and calendars shared with the public through campaign collaborators and the CSAs. The campaign is also in partnership with local broadcast affiliates, radio and television. Public service announcements (PSAs) were once again aired and will also be featured on all of the station's Web sites. In addition to traditional print and broadcast media, social media tools such as the Web site, Google Calendar, and Facebook Page will be utilized to disseminate information. Other media partners included in this campaign will also be featured on participating media Web sites. The campaign's Web site is www.childrensmentalhealthmatters.org.

MHAMD Outreach Campaign for Older Adults

Through the Mental Health Association of Maryland's (MHAMD) "Coalition on Mental Health and Aging," MHA, Maryland Department of Human Resources (DHR), Maryland Department of Aging (MDoA) state level staff work hand-in-hand with the Coalition membership to jointly plan opportunities, cross-trainings, client sharing responsibilities, and opportunities for additional partnerships. The Mental Health Association of Maryland and the Maryland Coalition on Mental Health and Aging continue to develop fact sheets, issue papers, and other documents for purposes of advocacy and information. "Mental Health in Later Life: a Guidebook for Older Marylanders and the People Who Care for Them" was produced by the Mental Health Association of Maryland to bring education and resources regarding important issues of mental health and aging to older Marylanders, caregivers, and helping professionals. Topics covered in the guidebook include positive mental health, indicators of mental illness, dementia, delirium, caregiver stress, finding professional help, how to help in times of concern, and more. A series of free guidebook study events took place during the summer of 2011, in collaboration with the Baltimore County Department of Aging, which facilitated deeper exploration and discussion of the issues found in the guidebook. The PDF version of the guidebook is available on MHAMD's mental health and aging Web site at www.mdaging.org.

Also, MHAMD has trained and certified more than 210 professionals to deliver mental health and aging education to assisted living providers. In FY 2011, the Mental Health Association offered affordable training to assisted living providers which satisfied Code of Maryland (COMAR) requirements for provider education/eligibility. In partnership with Montgomery County, MHAMD led the training for a pilot program in support of selected assisted living facilities serving high numbers of individuals with mental illness.

Additionally, MHAMD provided training focused on the issues of older adults in the areas of person centered care, Health Care Reform, trauma-informed care, and grief and loss. As appropriate, MHAMD folds Mental Health Advance Directive education into programs and trainings to both providers and consumers.

NAMI MD's NAMIWALKS

MHA works with NAMI MD and other stakeholders to support NAMIWALKS, a successful kick-off event for promoting *MAY MENTAL HEALTH MONTH*. Representatives from MHA attended meetings and advance events to promote and launch NAMIWALKS. In 2011, the annual NAMIWALKS, that takes place each May, was expanded to include two major walks; one in Baltimore City and one in Montgomery

County. The one which took place in Silver Spring on May 15th was attended by approximately 750 people. On May 21st, Baltimore City accommodated approximately 1,500 people. The awareness walks are designed to highlight the importance of education, advocacy, and support for persons diagnosed with a serious mental illness and their families. This annual event also helps reduce stigma often associated with mental illness by providing an opportunity for positive interactions and networking.

The National Alliance on Mental Illness' peer and family support education programs offer unique, experiential learning programs for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. In FY 2011, 245 participants completed the Family-to-Family Education Programs and 104 participants completed the Peer-to-Peer Education Program.

The Anti-Stigma Project

OOOMD and MHA continue to collaborate efforts to fight stigma within the mental health system through the Anti-Stigma Project (ASP). In FY 2011, the ASP presented 51 workshops throughout the state which trained 1,112 people in the full program and reached at least 259 additional participants at various venues such as psychiatric rehabilitation programs, housing authorities, homeless shelters, statewide conferences, and universities. Workshops may be designed and tailored to address specific populations and situations. A new workshop has been added on internalized stigma, “An Inside Look at Stigma,” as well as a workshop on creating non-stigmatizing environments. Through resources from the Mental Health Transformation – State Incentive Grant (MHT-SIG), ASP is collaborating with researchers to evaluate the quantitative impact of this training project and its possibilities as a best or promising evidence-based tool. Results from the evaluation will allow OOOMD to enhance this dynamic program and continue training across the country.

Network of Care

The Maryland Network of Care (NOC) for Behavioral Health continues to enhance Maryland residents' ability to access consumer driven and recovery oriented information regarding available mental health services. All of Maryland's 24 jurisdictions now have access to information and resources in their communities and specialized service information is provided for Maryland's Youth as well as a special portal for Veterans and families to help service men and women returning from Iraq and Afghanistan, with behavioral issues, obtain access to services. Core Service Agencies (CSAs) have been encouraged to support, at the county level, the expansion and promotion efforts of Network of Care. The use of NOC is encouraged and fostered in the Wellness and Recovery Centers, as well as other community settings, and plans are underway to train peer support specialists and peer educators to be able to train consumers on the use of NOC. Many consumers have received on-site training in the utilization of personal health record features and in the use of individual advance directives.

In FY 2011, the Maryland Network of Care for Behavioral Health has recorded 992,662. The veterans' portal recorded over 135,000 sessions from its launch in March 2009 through June 2011. (www.maryland.networkofcare.org).

Strategy Accomplishment:

This strategy was achieved.

(1-1C)

Explore efforts to enhance communication and education through use of social media tools and networks.

Indicators:

- Social media outlets explored to promote public mental health awareness and improve communication among MHA, CSAs, providers, advocates

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; John Hammond, MHA Office of Public Relations

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA, through DHMH departmental-wide efforts, established social media outlets, through Facebook and Twitter, as a means of disseminating mental health data and news among MHA, CSAs, providers, advocates, consumers, family members, and the public at large.

MHA has an individual Twitter account @DHMH_MHA which the administration has used to tweet information ranging from Consumer Handbook and Reference Guide content to news items regarding SmartPhone applications used to diagnose post-traumatic stress disorder (PTSD) by Veterans. Both social media sites are robust with information provided by the DHMH Secretary, staff, and other stakeholders that are involved with the administration. Continued expansion of the social media outlets and continued exploration of appropriate social media outlets to bolster child and adolescent initiatives and/or to provide peer-to-peer support will be conducted by MHA in FY 2012.

Strategy Accomplishment:

This strategy was achieved.

(1-1D)

Based on a requirement for DHMH as a federal grant-receiving agency and on instructions from the Governor's Chief of Staff, MHA will have an all-hazards approach to emergency preparedness and response for MHA as an administration (including facilities) and for the mental health community at large.

Indicators:

- Continued use of National Incident Management System (NIMS)
- Incident Command System (ICS) Chart maintained, ongoing NIMS/ICS training for Incident Command Team completed
- All-Hazards Disaster Mental Health Plan updated, Continuity of Operations Plan (COOP) for Pandemics and a general COOP plan updated
- Facility Evacuation Plans and Mass Fatalities Plans for MHA facilities developed and implemented, equipment purchased

Involved Parties: Arlene Stephenson, MHA Office of the Deputy Director of Facilities Management and Administrative Operations; Marian Bland, MHA Office of Special Needs Populations; Gail Wowk, MHA Emergency Preparedness; Facilities CEOs; Hospital Emergency Managers; CSAs

MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director of Facilities Management and Administrative Operations

FY 2011 activities and status as of 6/30/2011 (end-year report):

Currently, MHA's All Hazards Plan and Continuity of Operations Plan (COOP); both General and Pandemic, are up-to-date. All Hazards plans for psychiatric facilities are updated annually and each facility exercises elements of its plan at least two times per year. MHA has retained the University of Maryland Center for Health and Homeland Security to conduct Evacuation exercises at each of the facilities beginning in FY 2011 and concluding in FY 2012, so that all DHMH facilities will benefit and use lessons learned to enhance future evacuation plans.

National Incident Management System/Incident Command System (NIMS/ICS) training has been completed by all MHA essential personnel according to the Federal Emergency Management Administration (FEMA) requirements. MHA and each facility have an established ICS organization chart which has been updated and included in both the All-Hazards Plan and the COOP. MHA and the Developmental Disabilities Administration (DDA) have shared their plans and ICS organization chart with each other should one need to act on behalf of the other. Additionally, mass fatality equipment, such as storage and identification tools has been purchased and is stored at a central location in the State. Key staff at the facilities have attended a training on how to set up and use the equipment.

MHA's Office of Special Needs Populations provides facilitation, support, and technical assistance to enhance Maryland's ability to respond to the behavioral health needs that arise in the event of natural or man-made crises/disasters. The Office reviews, facilitates updates, and assists in the revision of the All-Hazards Mental Health Disaster Plans for MHA and all the Core Service Agencies and provides technical assistance and consultation on behavioral health emergency preparedness. Also, MHA, through the Office of Special Needs Populations, provides training to the Maryland Professional

Volunteer Corps (MPVC) and assists the MPVC in their recruitment of additional disaster behavioral health volunteers. Training was conducted for MPVC volunteers on Behavioral Health Considerations: Survivors and Responders on December 16, 2010. In addition, the office has conducted or provided technical assistance in identifying trainers to conduct disaster behavioral health trainings to CSAs as well as to other state agencies.

MHA participated in the Region III states (Maryland, Washington DC, Delaware, Pennsylvania, Virginia, and West Virginia) Disaster Behavioral Health Consortium Conference on June 21, 2011 which began discussions of developing a certification program for disaster mental health responders. Additionally, MHA has been working with the FEMA Region III Disaster Behavioral Health Coordinators and Braintree Solutions Consulting, Inc. to examine the newly developed disaster behavioral mental health operational plan template created for the Region III states and the best practices disaster behavioral mental health training curriculum.

Strategy Accomplishment:

This strategy was achieved.

Objective 1.2 MHA will continue efforts that facilitate recovery and build resiliency and develop mechanisms to promote health and wellness across the lifespan.

(1-2A)

MHA, in collaboration with On Our Own of Maryland (OOOMD), will support statewide activities promoting the continuance of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.

Indicators:

- Two facilitator follow-up trainings held
- Statewide wellness and recovery informational meetings held to educate providers
- Continued implementation of WRAP training in local consumer peer support and advocacy organizations across Maryland such as Wellness and Recovery Centers
- Continued training of Olmstead Peer Support Specialists as an additional WRAP resource for hospital discharge planning

Involved Parties: Clarissa Netter and Susan Kadis, MHA Office of Consumer Affairs; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; the Mental Health Transformation Office (MHTO); OOOMD; CSAs; Wellness and Recovery Centers

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA, in collaboration with MHTO and OOOMD, has continued the implementation of the Wellness Recovery Action Plan (WRAP) trainings, which include the core concepts of recovery: Hope, Personal Responsibility, Education, Self-advocacy, and Support, and incorporated them into all Wellness & Recovery Centers (previously known as drop-in centers) as a model for peer support. WRAP founder, Mary Ellen Copeland, visited a

Wellness & Recovery Center in August 2010 and attended, as a special guest, the Own Our Own of Maryland Annual Meeting in October 2010.

Maryland now has over 90 WRAP facilitators trained in a three-year period. Efforts to expand statewide activities were only partially completed due to the WRAP Coordinator's position becoming vacant during the fiscal year. Further WRAP facilitator trainings were put on hold from December 2010 until the end of the Fiscal Year. However, an Advanced Level training was held in April 2011 and five (5) facilitators are now Copeland Center certified Advanced Level WRAP Facilitators. A new WRAP Coordinator has been hired for FY 2012 to continue the guidance of this model program.

The Maryland Olmstead Peer Support Specialists, who facilitate consumer discharges and provide ongoing support during the consumers' transition into the community, are also WRAP facilitators and in FY 2011 received follow-up training of 16 hours to increase skill levels on special topics.

Strategy Accomplishment:

This strategy was partially achieved.

(1-2B)

Continue to implement, evaluate, and refine the Self-Directed Care project in Washington County and throughout the state.

Indicators:

- Self-directed care plans developed and approved with peer support workers assisting consumers with the process
- Continued WRAP training of consumer advocates and consumer participants with an emphasis on stress reduction and wellness
- Internet availability provided – Network of Care and use of advance directives for mental health treatment
- Proposal for new MHTO grant submitted to Substance Abuse and Mental Health Services Administration (SAMHSA); if funded, increased opportunities for career development and wellness and recovery for adults with serious mental illness (SMI) through the integration of: Evidence-Based Practice Supported Employment (EBP-SE) with On-site Benefits Counseling/Employed Individuals with Disabilities (EID), Self Directed Care, and WRAP

Involved Parties: Clarissa Netter, MHA Office of Consumer Affairs; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHTO; other MHA staff; CSAs; Washington, Howard and Harford County CSAs and providers; NAMI MD; OOOMD; Community Behavioral Health Association of Maryland (CBH); other interested parties

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA and the Mental Health Transformation Office (MHTO) implemented a consumer self-directed care pilot program in Washington County managed through the local Office of Consumer Advocates. As of FY 2011, the Self-Directed Care (SDC) program has 48

self-directed care plans developed and approved with two full-time and one part-time Peer Advocates assisting consumers with the process. Peer Advocates help consumers develop and implement their own “recovery plans”, which include directing the use of their benefits to access both public mental health services and non-traditional support services and other public mental health services tailored to meet their wants/needs.

Some of the goals that have been set include accessing better living conditions, obtaining a drivers license, obtaining a general education diploma (GED), attending college classes and quit smoking classes, and participating in exercise programs. Data sources include a report from the University of Maryland and anecdotal information that indicate some of these successful outcomes.

Additionally, individuals in the SDC program learn to independently manage their personal finances and are in various stages of developing or applying a plan for financial stability. To date WRAP training continues to be an integral part of the training the Peer Advocates and consumer participants receive with an emphasis on stress reduction and wellness.

Strategy Accomplishment:

This strategy was achieved.

Objective 1.3. MHA will increase opportunities for consumer, youth, family and advocacy organizational input into the planning, policy, quality assurance, evaluation, and decision-making processes.

(1-3A)

Participate in oversight of the Consumer Quality Team (CQT) project and plan for statewide expansion.

Indicators:

- Psychosocial programs and inpatient facilities in Maryland visited
- Continued expansion into counties, covering Maryland’s most populous regions and outlying jurisdictions
- Feedback meetings held, identified issues resolved, annual report submitted

Involved Parties: Clarissa Netter, MHA Office of Consumer Affairs; MHA Office of Planning, Evaluation, and Training; state facility representatives; MHTO; CSAs; MHAMD; NAMI MD; OOOMD; Community Behavioral Health Association of Maryland (CBH)

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Consumer Quality Team (CQT) initiative, which allows consumers and family members to play a direct role in the improvement of mental health services by recording and addressing individual consumers’ satisfaction with the services, entered its fourth year in FY 2011. CQT made 282 site visits reaching 89 sites and four inpatient facilities. The project continues to protect and enhance rights by obtaining first hand information

from consumers about their experiences in programs and takes an active role in resolving issues right at the program level and, as needed, at other system levels. Approximately 1,112 consumers were interviewed in FY 2011. Both consumers and program staff have reported significant program changes made as a result of the reports. The Eastern Shore and Finan Hospital Centers were especially responsive to recommendations made and gave a strong push toward enhancing programs by increasing recovery-oriented and consumer-involved endeavors. In general, it was found that providers are finding ways to pay more attention to the physical health needs of individuals such as introducing healthier meals and implementing programs that address somatic issues. Also some of the programs are utilizing the Johns Hopkins Achieve Program for healthier outcomes with consumers' somatic care.

Additionally, CQT continued the project to track the 63 consumers who were discharged as a result of the closure of the Upper Shore Hospital Center. Approximately 44 of the 63 individuals were interviewed, either in-person or by phone, and CQT is working with MHA and the appropriate CSAs to locate and interview the remaining individuals. As a result of this project, CQT expanded its activities into six programs in several jurisdictions on the Eastern Shore. Other major activities of the CQT in FY 2011 included sharing lessons learned and findings of the Consumer Quality Team at national and local mental health conferences. In working with various committees, projects, and councils, CQT has been instrumental in the development of the Peer Employment Specialist Toolkit and the curriculum for the Maryland Peer Support Specialist Certification Program.

Monthly feedback meetings regarding the PRP visits are also held with representatives from the appropriate local Core Service Agencies, provider organizations, and MHA. In addition, the leadership staff of CQT meets with the senior management staff of MHA on a quarterly basis to discuss the overall project, issues, trends, etc. As funding becomes available, the ultimate goal is to offer this initiative in all 24 jurisdictions and the remaining state-operated facilities.

Strategy Accomplishment:

This strategy was achieved.

(1-3B)

Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health (MCF) Leadership Institute for parents of children with emotional disorders; the Youth MOVE (Motivating Others through Voices of Experience) peer leadership program; and the Leadership Empowerment and Advocacy Project (LEAP) for adult consumers.

Indicators:

- Annual Family Leadership Institute convened, training activities for families implemented, number of graduates
- Youth MOVE implementation expanded, numbers of individuals enrolled in Youth MOVE, increased youth leadership participation in state and local policy committees and public awareness events
- LEAP redefined and expanded to include increased collaboration and participation at statewide trainings
- Increased consumer participation in Public Mental Health System (PMHS) state and local policy planning

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; Clarissa Netter and Susan Kadis, MHA Office of Consumer Affairs; MHTO; CSAs; OOOMD; MHA Office of Child and Adolescent Services; Maryland Coalition of Families for Children's Mental Health; Youth MOVE; the Maryland Child and Adolescent Mental Health Institute

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services and Clarissa Netter, MHA Office of Consumer Affairs

FY 2011 activities and status as of 6/30/2011 (end-year report):

Family Leadership Institute

The Maryland Coalition of Families for Children's Mental Health (MCF) held its fifth Family Leadership Institute (FLI) in FY 2011 to train families to advocate for their children and all of Maryland's children in their communities and across the state. The FLI graduated 23 participants from 13 jurisdictions, increasing the total number of trained family advocates to 115 over the five years of the Institute's implementation. The sessions were scheduled to allow for more participation and included Friday nights so that attendees were able to develop relationships with the presenters, organizations represented, and each other. Participants will hopefully use those connections to further advocate for their families and increased resources in the community.

Youth MOVE

Several jurisdictions have been able to create a youth-driven presence on the various system levels. A special issue paper on lessons learned during the initial stages of implementation, including issues of delayed expansion, was completed by the University of Maryland Innovations Institute. Recommendations included a much more hands-on approach to ensure that the appropriate levels of support are in place to establish a non-siloed statewide youth leadership presence; hiring of full or part-time regional youth engagement specialists; hiring a full-time supervisor/adult support; having all subcontracts go through the CSAs to allow jurisdictions to receive contracts and funding in a timely manner. The re-occurring theme across the jurisdictions is the need to provide more focused and intensive localized support for implementation and on-going sustainability of local Youth MOVE chapters. Youth MOVE grants to form local groups are on-going and the work to establish Youth MOVE statewide will continue into the next year.

LEAP

The Consumer Affairs Liaison within the MHA Office of Consumer Affairs (OCA) is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP) which has been funded by the MHA since 1990. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates and play a prominent role within state and local policy-making bodies. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state.

In FY 2011, 25 LEAP participants from across the state graduated from the program. The participants received Person-Centered Planning training from the ACT Peer Specialists trainers as well as workshops led by the Department of Legislative Services, Goodwill Industries of the Chesapeake, ValueOptions® Maryland, Community Behavioral Health, Inc., and On Our Own of Maryland, Inc. LEAP graduates continue to be in high demand for advisory boards, employment, and other leadership roles throughout the state.

Strategy Accomplishment:

This strategy was achieved.

GOAL II. PROMOTE A SYSTEM OF INTEGRATED CARE WHERE PREVENTION OF SUBSTANCE ABUSE AND MENTAL ILLNESS ARE COMMON PRACTICE ACROSS THE LIFE SPAN.

Objective 2.1. MHA, in collaboration with CSAs, the administrative services organization (ASO), managed care organizations (MCOs), behavioral health and health care providers, and other administrations and agencies, will continue to develop mechanisms to promote integrated health care.

(2-1A)

Continue to facilitate coordination of care activities throughout the Public Mental Health System (PMHS) and study data to determine impact of wellness activities and coordination of care in the provision of community mental health services.

Indicators:

- Utilization of existing interagency data to facilitate coordination of care i.e. pharmacy data (PharmaConnect)
- Providers trained on shared information system, continued development of care management/case management coordination through MHA-MCO Coordination of Care Committee
- Results of pilot project on issues of morbidity and mortality rates identified, data collected, wellness activities identified and developed, coordination of care facilitated throughout the system
- Increased access to registered public health providers through the ASO Web site, compliance activities monitored, and coordination of care activities administered through monthly meetings of medical directors of MHA and HealthChoice
- System integration of elements of coordination of care in PMHS through the Community Mental Health Medical Directors Consortium and the Managed Care Organizations Medical Directors

Involved Parties: Gayle Jordan-Randolph, MHA Office of the Clinical Director; DHMH Deputy Secretary for Behavioral Health and Disabilities, MHA Office of Compliance and Risk Management; MHA-MCO Coordination of Care Committee; Community Mental Health Medical Directors Consortium; Alcohol and Drug Abuse Administration (ADAA); MCOs; Medical Assistance-Office of Health Services; ASO

MHA Monitor: Gayle Jordan-Randolph, MHA Office of the Clinical Director

FY 2011 activities and status as of 6/30/2011 (end-year report):

While the results of the pilot project on issues of morbidity and mortality rates identified that most of the high cost consumers for many of the identified serious somatic issues were not a part of the Public Mental Health System, MHA will continue to monitor data, develop wellness activities, and facilitate coordination of care throughout the system. The pilot began its data collection phase in FY 2010 and in FY 2011 the provisional data was validated. MHA is collaborating with the MHA-MCO Coordination of Care

Committee, through monthly meetings, to identify other pilots to determine barriers and strategies for integrated care and to identify universal outcomes. Also, data mining continues within the Medicaid (MA) Pharmacy system to identify utilization patterns.

Additionally, MHA is collaborating with DHMH's Infectious Diseases and Environmental Health Administration (IDEHA) to identify behavioral health strategies to improve HIV/AIDS identification, tracking, and adherence to wellness strategies.

Strategy Accomplishment:

This strategy was partially achieved.

(2-1B)

In collaboration with the University of Maryland's Research, Education and Clinical Center and the Maryland Child and Adolescent Mental Health Institute, implement best practices in psychiatry to address reduction of negative side effects of medication, prevention of obesity, and reduction in morbidity and mortality rates for adolescents and children with serious mental illness or serious emotional disorder with focus on psychopharmacological practices for youth in both foster care and juvenile justice settings.

Indicator:

- Results of study on medication risk factors within a selected group of foster children identified, findings shared with providers throughout the PMHS and other child-serving agencies

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; other MHA staff; the University of Maryland, Community Psychiatry Division; the Maryland Child and Adolescent Mental Health Institute; the University of Maryland; Department of Human Resources (DHR); CSAs; Maryland Department of Juvenile Services (DJS); the Maryland State Department of Education (MSDE); NAMI MD; OOOMD; Maryland Coalition of Families for Children's Mental Health; Community Behavioral Health Association of Maryland (CBH); and other interested parties

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2010, a project to address the concern about appropriate use of psychopharmacological medication for children and adolescents, especially those in out-of-home placements, was developed and put into effect in collaboration with the Johns Hopkins University School of Medicine and the University of Maryland. In FY 2011, a Psychopharmacology Learning Collaborative, consisting of psychiatrists who provide services to youth in the juvenile justice system, was formed to examine the use and administration of psychotropic medication to youth in custody. Efforts of this Collaborative will include:

- A memorandum of understanding established with the Maryland School of Pharmacy to review utilization of psychiatric medications by children in foster care in Baltimore City
- A statewide review of Medicaid claims to be established for anti-psychotic medication prescriptions issued to children aged 0-4
- A peer review process to be put in place during FY 2012 to address circumstances when these practices are found and physicians notified that such prescribing is not considered within the normally acceptable range of practice.

Results from this project will be reported to MHA.

Strategy Accomplishment:

This strategy was partially achieved.

(2-1C)

Collaborate with the MDQuit Center of the University of Maryland – Baltimore County (UMBC), consumers, providers, and other mental health stakeholders to promote and implement the smoking cessation initiatives at all levels in the Public Mental Health System to reduce mortality rates.

Indicators:

- Utilization of tool kits and techniques to plan cessation initiatives in state facilities and community programs; provision of guidance and technical assistance to CSAs on successful cessation initiatives
- Smoking cessation implemented

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations, MHA Office of Adult Services; MHA Office of Child and Adolescent Services; other MHA staff; MHTO; CSAs; UMBC MDQuit Center; CBH

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordan–Randolph and Jean Smith, MHA Office of the Clinical Director

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA continues its collaborations with the Maryland QUIT Center of UMBC providing access to the latest data on smoking trends among multiple demographic groups and information on topics of current interest, e.g. Federal Drug Administration (FDA) involvement in the regulation of tobacco. Shared access to Maryland Quit resources include community trainings, DVDs, on-line assistance, and help lines. MD Quits offers consultation to community providers on utilization of toolkits and technical assistance is available to CSAs upon request.

Maryland was one of only a half-dozen states selected by SAMHSA to participate in a Leadership Academy for Wellness and Smoking Cessation Summit. The policy academy included key staff from MHA, ADAA, and DHMH's public health programs as well as representatives of non-profit, consumer, and advocacy agencies. As such, the state received the assistance of the nationally renowned Smoking Cessation Leadership Center

for a summit focused on reducing smoking prevalence among people with behavioral health disorders. The purpose of the two day session, held on May 31 and June 1, 2011, was to design an action plan for Maryland to reduce smoking and nicotine addiction among behavioral health consumers and staff, and to create an environment of collaboration and integration among the fields of public health (including tobacco control and prevention), mental health, and substance use prevention. Smoking cessation has been successfully implemented in most MHA facilities. Under the leadership of DHMH Deputy Secretary for Behavioral Health and Disabilities, an integrated strategy was developed and is now in the implementation phase with clear goals established for the next three years.

Strategy Accomplishment:

This strategy was achieved.

(2-1D)

Implement the provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from the Center for Medicare/Medicaid Services (CMS) to examine and refine Care Management Entity (CME) approaches through a multi-state (Maryland, Georgia, and Wyoming) Learning Collaborative and evaluate the impact of care management on children and families enrolled.

Indicator:

- Contracts developed with state partners

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; the Maryland Child and Adolescent Mental Health Institute; the University of Maryland; Department of Juvenile Services (DJS); Department of Human Resources (DHR); CMS; MCF; Center for Healthcare Strategies; State of Georgia; State of Wyoming; other interested parties

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

Maryland applied successfully to CMS for the CHIPRA Quality Demonstration grant as the head of a consortium of states, which includes the states of Georgia and Wyoming. The grant is the only behavioral health grant among all those awarded by CMS, focusing on the implementation, expansion, and sustainability of Care Management Entities (CMEs) with continuing exploration of growth of the CME structure for home and community-based services. As a result, the five-year CHIPRA Quality Demonstration becomes an anchor in the sustainability planning for CMEs and system of care efforts started under the 1915(c) and SAMHSA System of Care (SOC) grants. In Maryland, specific goals of the grant are:

- Improve utilization management functions for youth enrolled in the CME program
- Ensure appropriate use of medication with children and youth
- Develop a case rate(s) for populations served by CMEs
- Refine practice models and identify consistent funding mechanisms for peer-to-peer support

- Enhance the Wraparound Practitioner Certificate Program to include modules on additional preventive health topics
- Identify a statewide crisis response system model for children and youth

All the contracts with partner states have been put into effect and staff in all three states have been hired. A technical assistance vendor contract has been finalized. Project activities will be structured in a Quality Learning Collaborative framework to inform other states and CMS about effective approaches and challenges to implementation of the CME provider model. Two meetings of the Learning Collaborative have been held and members of the collaborative participated with all of the CHIPRA Quality Demonstration Grantees in the first CMS quality Conference in August 2011 in Baltimore. A series of Webinars on various topics related to Care Management Entities was presented.

Strategy Accomplishment:

This strategy was achieved.

(2-1E)

Continue to interface and maintain liaison efforts with other agencies and administrations to support a comprehensive system of behavioral and somatic health and other services and community supports.

Indicators:

- Maintain liaisons and participate on joint projects with the following entities:

Examples of interface with other agencies include, but are not limited to, the following:

- **Maryland Department of Disabilities (MDOD)**, Brian Hepburn, Monitor – MHA continues to collaborate with MDOD in the development and implementation of cross-agency initiatives such as Money Follows the Person and transition-age youth projects. Additionally, MHA and MDOD collaborate to facilitate outreach to Employed Individuals with Disabilities (EID) applicants and identify action steps to promote affordable housing efforts throughout the state via the MDOD Housing Task Force. The Interagency Disabilities Board is charged with continuously developing recommendations; evaluating funding and services for individuals with disabilities; identifying performance measures; and working with the Secretary of MDOD to create a seamless, effective, and coordinated delivery system. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Governor's Office for Children (GOC)**, Albert Zachik, Tom Merrick, and Marcia Andersen, Monitors – GOC and MHA are active partners in implementing the Wraparound and Psychiatric Residential Treatment Facility (PRTF) Waiver initiative for Maryland. MHA staff meets at least weekly with GOC staff to coordinate all efforts. The office coordinates inter-governmental efforts and the State Coordinating Council for service delivery planning for children with special needs. The Children's Cabinet Interagency Plan is monitored each year and intersects with MHA's ongoing planning processes.

- **Governor's Office of Deaf and Hard of Hearing (ODHH)**, Marian Bland, Monitor – MHA's Director of the Office of Special Needs Populations continues to interface with ODHH by serving as DHMH's representative on the Maryland Advisory Council for Deaf and Hard of Hearing and participating in the behavioral health subcommittee meetings. MHA consults with ODHH on resources as well as collaborates to address consumer and/or system related issues; coordinates or sponsors cultural sensitivity and awareness trainings; and provides data on number of deaf and hard of hearing consumers served at Springfield Hospital Center and/or in the community. MHA and ODHH also collaborate to exchange technical assistance in resolving access issues and examine national best practices.
- **Maryland State Department of Education (MSDE)**, Albert Zachik and Cyntice Bellamy, Monitors – MHA meets with the Assistant Superintendent for Special Education at MSDE to collaborate on mutual concerns involving the mental health needs of children in school and early childhood settings. Collaborative efforts continue regarding the Maryland Mental Health Workforce Initiative. MHA continues to collaborate with MSDE to develop and enhance behavioral health programs for students in need of services throughout the state. MHA is currently represented on the State Interagency Coordinating Council (SICC); Early Childhood Mental Health Consultation Leadership Group; and the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) Planning Committee. This department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Division of Rehabilitation Services (DORS)**, James Chambers and Steve Reeder, Monitors – Joint efforts included implementation of the evidence-based practice model of supported employment (SE) that establishes a single point of entry for SE services in the MHA's and DORS' systems, and allows for the dissemination of shared data and outcomes. MHA and DORS executive leadership teams have met frequently over the course of the year to explore interim and long-term strategies for reconciling gaps in vocational rehabilitation funding in an effort to preserve the viability of SE services within the PMHS and to sustain the gains in cross-systems integration. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Human Resources (DHR)**, Marian Bland, and Albert Zachik, Monitors – MHA's Office of Special Needs Populations continued to interface with DHR through: local implementation of state's Supplemental Social Security, Outreach, Access, and Recovery (SOAR) program; supportive services match for Shelter Plus Care grants; sponsoring and providing training; collaborating on homelessness issues; applying for homeless continuum of care funding; and accessing data on the number of homeless persons in Maryland. MHA and DHR collaborate on ongoing efforts with two system of care grants and with Baltimore City psychopharmacy and health suite projects. MHA maintains strong liaison with the Social Services Administration and Maryland's child welfare agency for a number of special projects and all matters related to serving foster care children. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **Department of Housing and Community Development (DHCD)**, Penny Scrivens and Marian Bland, Monitors – MHA coordinates with DHCD to obtain certifications for consistency with the Consolidated Plan in order to apply for funding through the Housing and Urban Development (HUD) Continuum of Care. Additionally,

MHA's Office of Special Needs Populations provides technical assistance to DHCD with completing the homeless section for DHCD's Annual Caper Report to HUD. MHA participates on DCHD's applicant review panel for agencies seeking emergency and transitional funding. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland Department on Aging (MDoA)**, James Chambers and Marge Mulcare, Monitors – MHA and MDoA have close contact regarding policies, initiatives, strategic planning, etc. regarding both agencies and the populations served. MHA continues to partner with MDoA through its "Chronic Disease Self-Management" initiative, an evidence-based practice which consists of a series of classes that assist participants in the management of acquired chronic diseases. MHA provides training, consultation, and assistance in fostering interagency connections between the local areas on aging and the CSAs; specifically in identifying older adult participants eligible to receive services through the PMHS. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Department of Public Safety and Correctional Services (DPSCS)**, Larry Fitch and Marian Bland, Monitors – MHA liaisons with DPSCS regarding individuals who require civil certification to MHA facilities, who hold the status of mandatory release, and/or who present complex cases. The Director of MHA Office of Forensic Services (OFS) co-chairs the quarterly meetings of the Interagency Forensic Services Committee of the Maryland Advisory Council on Mental Hygiene/Planning Council, with members representing DPSCS, the courts, Alcohol and Drug Abuse Administration (ADAA), and Developmental Disabilities Administration (DDA). MHA's Office of Special Needs Populations meets at least monthly with DPSCS, the Mental Health/Substance Abuse subcommittee, and leads the Department's criminal justice "dream team" initiatives. MHA serves as liaison for addressing criminal justice issues; participates in various meetings; provides SOAR training to DPSCS social work staff; and co-chair mental health and substance subcommittee of the Maryland Correctional Administrators' Association. Additionally, MHA collaborates with DPSCS regarding the operation of the Chrysalis House Healthy Start Program.

- **Department of Juvenile Services (DJS)**, Albert Zachik, Cyntrice Bellamy, and Larry Fitch, Monitors – MHA's Office of Child and Adolescent Services: meets regularly with the Behavioral Health Director of DJS to plan mental health services; oversees behavioral health programs for youth in the juvenile justice system; and works in consultation with both DJS and MSDE on initiatives involving children's mental health. MHA is a member of the DJS Sex Offender Task Force and hosts annual trainings and conferences. MHA sits on the Facility for Children Interagency Committee, which this year drafted GOC regulations for the juvenile competency statute. MHA maintains an advisory role with the Administrative Office of the Courts regarding juvenile justice issues. This Department is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland National Guard (MNG)**, Marian Bland, Monitor – MHA collaborates with representatives of the U.S. Department of Veterans Affairs, the Maryland Department of Veterans Affairs, the Maryland National Guard, and the Maryland Defense Force through participation in the Veterans Behavioral Health Advisory Board

and staff for the Children, Family, and Special Populations subcommittee. Maryland maintains the Network of Care Web site for veterans and service members.

- **Maryland Department of Veterans' Affairs (MDVA)**, Marian Bland, Monitor – MHA collaborates with representatives of the U.S. Department of Veterans Affairs and the Maryland Department of Veterans Affairs through participation on the Veterans Behavioral Health Advisory Board and staff for the Children, Family, and Special Populations subcommittee. MHA also offers technical assistance with implementing specialized SOAR initiative for veterans; participates in meetings and provides resources.
- **Judiciary of Maryland**, Larry Fitch, Monitor – The MHA Office of Forensic Services (OFS) has ongoing contact (meetings, phone, e-mail) with the judges of the Baltimore City District Court, the Prince George's County Mental Health Court, and other courts throughout the state on a variety of issues including the establishment of community-based mental health alternatives to incarceration for individuals evaluated at MHA facilities. OFS provided training in the Baltimore City Circuit Court on mental health evaluations of competency and other competency issues. Also, OFS staff attended meetings of the Baltimore City Mental Health Court Workgroup, the Baltimore County Forensic/Mental Health Workgroup, and the Montgomery County Criminal Justice Behavioral Health Initiative.
- **DHMH Alcohol and Drug Abuse Administration (ADAA)**, Pat Miedusiewski, Monitor – Collaborations continue under the auspices of DHMH's Behavioral Health and Disabilities. During the past year MHA has participated with ADAA, DDA, and various providers in initiating the development of competencies, curricula, and cross-training processes to enhance training and services statewide; especially the Co-Occurring Disorders Supervisors' Academy. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **DHMH Family Health Administration (FHA)**, Al Zachik, Monitor – MHA collaborates on Maryland's implementation of the Nurse-Family Partnership[®] (an evidence-based, nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children) and works closely with FHA on the Early Childhood Mental Health Steering Committee.
- **DHMH Developmental Disabilities Administration (DDA)**, Stefani O'Dea, Debra Hammen, and Lisa Hovermale, Monitors –MHA/ DDA/ ADAA bi-weekly clinical and leadership meetings continue. Regular meetings between DDA staff and state hospital staff (and with community-based PMHS providers on an as-requested basis) occur to brainstorm/problem solve for individuals/patients with developmental disabilities and mental illness who are facing challenges in transition to the community. MHA and DDA are in the process of developing an automated data reporting system to track individuals with DDA-involvement who are admitted to MHA facilities. MHA meets regularly with Johns Hopkins Bayview Special Needs Clinic and Sheppard Pratt Health System's Adult Neurobehavioral Unit and provides education and training regarding people with intellectual disabilities and mental illness whenever possible. Additionally, OFS Staff communicate weekly with DDA regarding court-involved individuals who require evaluation by MHA, DDA, or jointly by both agencies. This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.

- **Maryland Health Care Commission (MHCC)**, Brian Hepburn, Monitor – MHA collaborates with MHCC on health policy studies involving mental health services, reimbursement rates for hospitals, and on issues involving health insurance coverage and the uninsured population.
- **Health Services Cost Review Commission (HSCRC)**, Brian Hepburn, Monitor – MHA and HSCRC meet periodically to maintain communication and consultation regarding the rate setting process for hospital rates for inpatient services.
- **Children’s Cabinet**, Al Zachik, Monitor – MHA’s Director of the Office of Child and Adolescent Services is an active member of the Children’s Cabinet, meeting regularly with senior staff from the participating child-serving agencies to plan services across agencies for children, youth, and families. A wide variety of policy issues are considered and acted upon under the broad umbrella of the Interagency State Plan. MHA coordinates with the Cabinet on the care management entities demonstration process and other issues of system of care as well as collaborates with other agencies to review the summary of implementation data from the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). MHA also Works with the Children’s Cabinet on evidence-based practices for home visiting and partners with the Maternal and Child Health Bureau at DHMH.
- **DHMH Office of Health Services & DHMH Office of Operations and Eligibility (Medical Assistance)**, Brian Hepburn, Gayle Jordan-Randolph, and Daryl Plevy, Monitors – MHA participates in the Maryland Medicaid (MA) Advisory Committee and the DHMH Roundtable. Participation in the Medical Care Organizations’ (MCOs) monthly medical directors meeting continues. MHA has continued to work with the offices within Maryland’s Medical Assistance program on such issues as the Primary Adult Care program, the National Provider Identifier, claims processing through the Federal Financial Participation, case management reimbursement, and other relevant MA waivers such as Money Follows the Person. MHA and MA are currently coordinating drafting of 1915(i) State Plan Amendment for psychiatric rehabilitation services and completing coordination of a successful state plan amendment on telemental health services. Additionally, work continues with Operations on drafting technical specifications for Institutes of Mental Disease (IMDs) for Medicaid Emergency Psychiatric Demonstration. MHA will continue to work with Eligibility to ensure that Medicaid is the payor of last resort for dually eligible persons (those with private insurance, Tricare, and/or Medicare). This agency is represented on the Maryland Advisory Council/P.L. 102-321 Planning Council.
- **DHMH Office of Health Care Quality (OHCQ)**, Audrey Chase and Sharon Ohlhaber, Monitors – Regular meetings between MHA and OHCQ staff continue. Program specific issues and issues related to regulatory interpretation and compliance continue to be discussed and addressed. In addition, OHCQ and MHA instituted quarterly meetings with potential program applicants (four meetings were held: September 2010, December 2010, March 2011, and June 2011). Other activities involving OHCQ included 1) participation in meetings related to the program licensure process, chaired by DHMH’s Deputy Secretary of Behavioral Health and Disabilities and 2) participation in meetings related to regulatory oversight, chaired by DHMH’s Assistant Secretary for Regulatory Affairs.

- **DHMH Office of Capital Planning, Budgeting, and Engineering Services,** Cynthia Petion, Monitor – MHA, in collaboration with this Office, processes requests for the DHMH Administration-Sponsored Capital Program (Community Bond Program) for Community Mental Health, Addictions, Developmental Disabilities Facilities, and for Federally Qualified Health Centers. The Community Bond program provides capital grant funds for prioritized community-based services such as the development of affordable housing for individuals with serious mental illnesses (SMI).
- **DHMH Infectious Disease and Environmental Health Administration (IDEHA) [formerly AIDS Administration],** Marian Bland and Darren McGregor, Monitors – MHA participates in HIV/AIDS community planning meetings and provides resources and education on trauma. MHA also collaborates with this administration to provide HIV/AIDS risk awareness and prevention strategies for TAMAR (Trauma, Addictions, Mental Health, And Recovery), a program for incarcerated men and women who have histories of trauma and mental illnesses. Additionally, MHA participates in monthly/quarterly meetings with IDEHA to address behavioral health needs of individuals with special needs.
- **Maryland Emergency Management Administration (MEMA),** Gail Wowk and Marian Bland, Monitors – In FY 2010 MHA continued its liaison and partnership with MEMA (the state agency responsible for mass care and shelter), DHMH's Office of Preparedness and Response, the Maryland Department of Disabilities, and Department of Human Resources (DHR). This has been achieved through meetings, ongoing communications, and through trainings and presentations offered by MHA to involved state agencies.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.2. MHA will work with the CSAs and other stakeholders to develop, implement, and evaluate screening, prevention, and early intervention services across the life span for individuals with psychiatric disorders or individuals who are at risk for psychiatric disorders.

(2-2A)

In collaboration with the Maryland Child Adolescent Mental Health Institute, the Maryland State Department of Education (MSDE), the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve the quality of mental health screening assessment and intervention for young children.

Indicators:

- University of Maryland Early Childhood Mental Health Certificate program expanded to Bachelor's level participants – An additional 36 professionals trained
- The Maryland implementation of the Nurse-Family Partnership® (an evidence-based, nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children) explored
- Summary of implementation data from the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) reviewed

Involved Parties: Al Zachik, MHA Office of Child and Adolescent Services; MSDE; Center for Maternal and Child Health; the Maryland Blueprint Committee

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The purpose of the Early Childhood Mental Health (ECMH) Certificate Program is to offer specialized training to clinicians in core knowledge, skills, and attitudes necessary for practicing in the field of early childhood mental health. The University of Maryland Early Childhood Mental Health Certificate program expanded to Bachelor's level participants with an additional 36 professionals trained at the end of FY 2011. The University of Maryland Center for Infant Study provided instruction to 27 participants. Of the 27 participants, 22 were staff from the Early Childhood Mental Health Consultation Project, four were staff from Baltimore City Head Start, and one was from the Anne Arundel County Judy Center. Participants were both bachelors and masters level prepared and represented a variety of disciplines including child care, mental health, and education.

Maryland has been exploring implementation of the Nurse-Family Partnership® (an evidence-based, nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children) The Governor's Office for Children (on behalf of the Children's Cabinet) and DHMH/Center for Maternal and Child Health (CMCH) have collaborated to administer all Maryland's Home Visiting Programs as part of federal funding made available through the Affordable Care Act and Maryland has been allocated \$1 million for five years beginning in FY 2010. For FY 2011 – FY 2014 additional funds are expected to be awarded through a competitive application process. In July 2010, DHMH completed the initial application and in

September 2010, the initial needs assessment was completed. In addition a state planning team has been convened. As a result of the needs assessment, 46 "most at risk communities" were identified and five were identified as "hot spots". Next steps include beginning local planning for most at risk communities, developing bench marking and data systems, and completing the application for competitive funds.

Maryland, through CSEFEL and MSDE, is participating in a training and technical assistance project to foster the professional development of the early care and education workforce. Maryland CSEFEL has reported the following successes in linking to existing programs and services:

- CSEFEL has been aligned with: Early Childhood Mental Health (ECMH) Standards of Practice, ECMH Certificate Program, ECMH Core Competencies, and Social and Emotional Learning Parties developed by Ready at Five Partnership
- CSEFEL has been approved by: the Office of Child Care for Core of Knowledge Clock Hours for child care and Head Start staff; the MSDE for continued professional development credits for teachers in local school systems
- CSEFEL has been approved for funding through the Maryland Model for School Readiness (MMSR) grant to align with the social/personal domain

Sixteen out of 24 local school system administrators have accessed funding through grant opportunities from the MSDE Division of Special Education/Early Intervention Service as part of their MMSR grant. Additionally, CSEFEL is an integral part of the Governor's Early Childhood Advisory Council three-year action plan which addresses physical health and social and emotional development in young children.

Strategy Accomplishment:

This strategy was partially achieved.

(2-2B)

MHA will work in conjunction with Department of Human Resources (DHR), Care Management Entities (CMEs), and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.

Indicators:

- CME data reporting on various child welfare initiatives
- Systems of Care grants - MD CARES and RURAL CARES – implemented in Baltimore City and nine Eastern Shore Counties
- Crisis Response and Stabilization Service Initiative continued for children placed in foster care settings

Involved Parties: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services; the Maryland Child and Adolescent Mental Health Institute; DHR; Maryland Coalition of Families for Children's Mental Health; CSAs; local Department of Social Services (DSS) offices

MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MD CARES and Rural CARES

Funded through two SAMHSA Systems of Care grants for youth in child welfare in Baltimore and the Eastern Shore counties of Maryland, MD CARES and Rural CARES projects have been implemented to expand and support “wraparound” services to foster children in their communities. MD CARES in Baltimore City served 30 youth in FY 2011 and Rural CARES served 50.

Care management is provided for youth placed at the group home level by both DHR and DJS and for the two System of Care grants. Contracts have been awarded to two private vendors to deliver the service of interagency Care Management Entities (CMEs) statewide and the CMEs continue to provide services to youth in foster care within their respective jurisdiction. Through the Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant, Maryland is actively involved in a major sustainability project to maintain and expand the CME infrastructure.

Maryland’s Crisis Response and Stabilization Service

Maryland’s Crisis Response and Stabilization Service Initiative provides 24/7 crisis services to youth in foster care within 13 jurisdictions. This service helps respond to children in kinship care, in-home and foster care placements and intervene in the home setting so that psychiatric crises and resulting hospitalizations do not result in the disruption of the child’s residential placement. The programs within the jurisdictions operate as a mobile crisis program which is available 24 hours daily. The original integrity of the program has been realized in addition to some new programming to enhance the existent program. Some services added by jurisdictions include individual therapy, respite, and assistance with voluntary placement cases. Nine service provision areas covering 16 counties have been initiated. These include the Lower Shore region; Mid-Shore region; Allegany, Garrett, Washington, Baltimore, and Anne Arundel counties; and Baltimore City. However, further expansion of this project has been curtailed due to budget limitations. To date, eleven of the jurisdictions where this service is available have met or exceeded the expectations of the program. Additionally, anecdotal summaries are in the process of being collected.

Strategy Accomplishment:

This strategy was achieved.

(2-2C)

MHA will work in conjunction with MSDE, local school systems, and a wide range of other interested stakeholders to improve access to and quality of school mental health services provided to school-aged children.

Indicators:

- Participation on workgroups of the Steering Committee on Students with Emotional Disabilities in Educational Settings and the Maryland Blueprint Committee's School Mental Health Sub-Committee
- Develop, finalize, and disseminate recommendations on behavior management, stigma, appropriate screening guidelines, implementation of individualized education plans, and transition to independence process principles

Involved Parties: Cyntrice Bellamy, MHA Office of Child and Adolescent Services; MSDE; the University of Maryland Center for School Mental Health; the Steering Committee on Students with Emotional Disabilities in Educational Settings; the Maryland Coalition of Families for Children's Mental Health; local school systems; CSAs; private providers

MHA Monitor: Cyntrice Bellamy, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Mental Hygiene Administration continues to serve as a consultant, when needed, with Maryland State Department of Education to address the mental health needs of children within the school system. In addition, mental health services through the PMHS are available in more than 120 public schools in Baltimore City and in five schools in Baltimore County. There are currently more than 60 school-based health centers across the state, each of which provides somatic services. Approximately half of these centers also provide mental and behavioral health services.

Mental Hygiene Administration staff participated in the workgroups of the Steering Committee on Students with Emotional Disabilities. The Mental Health Association was the leader in coordinating an Emotional Disturbed Steering Committee. House Bill 11 was initiated by some members of this committee to eliminate stigmatizing language by changing the term "emotional disturbance" to "emotional disability". This change in language became effective as of October 1, 2010 in special education settings and elsewhere.

The Steering Committee on Students with Emotional Disabilities in Educational Settings developed a draft report in FY 2010, finalized it in FY 2011, and made it available to the public at www.msde.maryland.gov/NR/rdonlyres. The report included: recommendations on implementing a strengthened comprehensive system of care; development of a statewide curriculum on social/emotional development; increased engagement of student and families; and the expansion of data, research, and analysis agenda.

Strategy Accomplishment:

This strategy was achieved.

(2-2D)

MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.

Indicators:

- Continued implementation of pilot projects for identified high risk counties, prevention activities, and training within local school systems under the Maryland Linkages to Life Grant
- Continued monitoring of utilization of Youth Suicide Hotlines for increased access resulting from passage of Maryland legislation, House Bill (HB) 973, which requires schools to provide the crisis phone number and related information to students in grades 6-12.
- DHMH/MHA participation in the Governor's Commission on Suicide – minutes posted on DHMH Web site and workgroups established to focus on issues of various populations

Involved Parties: Henry Westray, MHA Office of Child and Adolescent Services; James Chambers, MHA Office of Adult Services; Maryland Department on Aging; Youth Crisis Hotline Network; the Maryland Committee on Youth Suicide Prevention; MSDE; CSAs; Johns Hopkins University; University of Maryland; Local school systems; other key stakeholders

MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Garrett Lee Smith Youth Suicide Prevention Grant

The Garrett Lee Smith Youth Suicide Prevention Grant, also known as Linkages to Life: the Maryland State Plan for Suicide Prevention, FY 2008-2012, was developed to improve public awareness of youth and young adult suicide and the availability of programs and resources. The plan promotes strategies to help decrease suicide; overcome stigma; ensure delivery of prevention, intervention and post-vention approaches; and provide programs in a culturally competent manner. Contract/Grant Personnel at Johns Hopkins University are helping to manage and implement the grant, including all local and federal evaluation activities and cross-site evaluation such as training exit surveys, early identification and referral forms, and on-line surveys. CSAs are managing the administration of funding to 28 sub-awardees, organizations working with high-risk groups, and specialized projects. These include community advocacy organizations such as National Organization for People of Color Against Suicide (NOPCAS), Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) Community Center, community crisis services, local Mental Health Association chapters, and public schools, especially those in high risk areas.

Also, between July 1, 2010 and June 30, 2011, the following examples of activities were accomplished through the Grant in identified high risk counties:

- Training of community members, faith-based organizations, and child protective services as trainers or gatekeepers under the grant in Maryland during the specified reporting period. Gatekeeper models employed included: Applied Suicide Intervention Skills

Training (ASIST); Question, Persuade, Refer (QPR); YellowRibbon; and safeTALK (Tell, Ask, Listen, Keep safe). Additionally, nearly 3,000 individuals who work with youth have been trained as gatekeepers in evidence-based suicide prevention models.

- Promotion of suicide awareness in schools through health curriculum revisions and presenting materials to parents at back-to-school nights. The number of individuals who were exposed to mental health awareness messages was 67,587 and 304 youth were referred to mental health services (documented; this number is likely higher) with 56 youth receiving mental health services after referral.
- Utilization of consultants from the Maryland State Department of Education provided resources and information related to suicide prevention in Maryland's public schools. In addition, new chapters of Active Minds, a youth based organization, are being formed in Maryland's high schools. Novel initiatives to reach college-aged youth have been funded, such as the Worcester County Health Department implementation of a comprehensive suicide prevention and intervention project with college aged youth at the colleges and universities in its county as well as with teens and young adults who are temporary residents of Ocean City during senior week, spring break, and summer season.
- The Maryland Youth Crisis Hotline Centers, between July 1, 2010 and June 30, 2011, answered 8,554 calls. Each call center reports caller data to the Johns Hopkins grant team on a quarterly basis. Also, there is continued enhancement of efforts of Crisis Response Teams to follow-up with youth identified as at-risk for suicide.

The Garrett Lee Smith Youth Suicide Prevention Grant was due to end on September 29, 2011; however, MHA applied for and received a Federal No-Cost Extension to continue youth suicide prevention, intervention, and post-vention activities through September 29, 2012.

Maryland Commission on Suicide Prevention

In October 2009, Maryland's Governor O'Malley signed an Executive Order to create the Maryland Commission on Suicide Prevention. The 21-member commission is comprised of members from various state departments, the Legislature, advocacy organizations, along with a family member of an individual who completed suicide and a suicide survivor. The Commission is charged with the development of a comprehensive, coordinated, strategic plan for suicide prevention, intervention, and post-vention services across the state. Recently, the Commission divided into three Workgroups, to focus on three areas: Public Awareness, Prevention/ Intervention, and Post-vention. Also, strategies to be included in the plan might be specified to a special high-risk population(s) such as veterans or LGBTQ. Each Workgroup is charged with discussing overarching strategies that:

- Advance the science of suicide prevention
 - Test, replicate and utilize new strategies (promising and evidence-based practice pilot sites) as appropriate throughout the state
- Support MHA's Mission and Values statements that reflect concern for all persons with mental illness of all ages, supporting a consumers' right to access appropriate mental health services in all suicide prevention, intervention, and post-vention efforts

- Develop more coordinated prevention, intervention, and post-vention services across the state for all ages.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.3. MHA, in collaboration with the CSAs and other stakeholders, will continue to facilitate the development, implementation, and evaluation of services that address the needs of children, adolescents, transition-age youth with psychiatric disorders, and their families.

(2-3A)

MHA, in collaboration with Maryland Department of Disabilities (MDOD), Department of Human Resources (DHR), Maryland State Department of Education (MSDE), and other stakeholders, will develop integrated home and community-based services and supports for youth and young adults in transition through the Healthy Transitions Initiative demonstration project in Washington and Frederick Counties.

Indicators:

- Establish seamless referral protocols to link youth-serving agencies with the PMHS for services to transition-aged youth
- Identify involved systems and services and review eligibility criteria
- 67 youth and young adults in transition served

Involved Parties: Tom Merrick, MHA Office of Child and Adolescent Services; Steve Reeder, MHA Office of Adult Services; MDOD; MSDE; CSAs; DHR; Maryland Coalition of Families for Children's Mental Health; Youth MOVE; Governor's Interagency Transition Council for Youth with Disabilities; Maryland's Ready by 21; the University of Maryland; local school systems; parents; students; advocates; other key stakeholders

MHA Monitor: Tom Merrick, MHA Office of Child and Adolescent Services and Steve Reeder, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Healthy Transitions Initiative demonstration project develops integrated home and community-based services and supports for Transition-Age Youth. The project is currently fully operational and entering year three of its five-year funding period. Five transition facilitators were hired through the two local CSAs in Washington and Frederick counties and a Project Manager monitors both sites. The referral mechanism has been established within the two pilot site counties and referrals have been received from a wide variety of sources. The local and state system players have all been identified and eligibility criteria have been established. The provider organization has changed policies and procedures in the areas of personnel training, hours of service, access to electronic communication, reporting and documentation protocol, and collaboration with existing internal services providing evidence-based practices. In FY 2011, 59 youth and young adults were enrolled in programs at the two sites – Way Station in Frederick County and Way Station in Washington County.

The Healthy Transitions Initiative (HTI) employs the Transition to Independence Process (TIP) model with a combination of a team of transition facilitators and expanded access for youth to both evidence-based supported employment and assertive community treatment (ACT), if needed. Mutually beneficial partnerships have been established with Maryland-based chapters of NAMI, MCF, On Our Own, and Youth MOVE. Local Implementation Committees have been established in Frederick and Washington counties to further address such issues while the HTI State Advisory Committee actively addresses state level collaboration and alignment with broader scoping state plans.

An initial TIP training took place in FY 2010 and HTI has also facilitated training and educational events on local, state, and national levels to increase awareness and understanding of transition related issues of youth and young adults with mental health disorders.

Strategy Accomplishment:

This strategy was achieved.

(2-3B)

MHA, in collaboration with other state agencies, will participate in Maryland's Commission on Autism to evaluate and increase understanding of services that address the needs of Maryland families with children and adults with Autism Spectrum Disorders.

Indicators:

- Information disseminated as appropriate to assist families in service delivery

Involved Parties: Al Zachik, Marcia Andersen, and other staff, MHA Office of Child and Adolescent Services; Renata Henry, DHMH Office of the Deputy Secretary of Behavioral Health and Disabilities; Maryland Department of Disabilities (MDOD); MSDE; DHR; the Kennedy Krieger Institute; the University of Maryland; parents; students; advocates; other key stakeholders

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

On October 1, 2009, Governor O'Malley appointed the membership of the Maryland Commission on Autism to develop a comprehensive statewide plan for an integrated system of services, training, and treatment for persons with autism spectrum disorders, including a focus on health care, education, and adolescent and adult issues. The commission consists of 26 members, including the DHMH Deputy Secretary for Behavioral Health and Disabilities who serves as Chair, representatives from various state and consumer protection agencies, parents, schools, therapists, pediatricians, and advocates. The Commission held its first meeting in November 2009 and since then, has held seven meetings. Four of the meetings were designated as "listening sessions" and held in four different parts of the state – western, central, southern and eastern. These sessions included a panel of speakers as well as opportunities for public comment which provided the Commission with insight into regional issues.

An interim plan was presented in August, 2011 which addressed five themes: access, quality, communication, training, and funding. These themes assisted the Commission to envision what a comprehensive system of services and supports would include. The Commission will continue to conduct most of its work within seven workgroups established during its first year of operation (adult service system, evidence-based practice, funding and resources, health/medical services, research partnerships, transition age youth, and workforce development). A final report is due to the Maryland General Assembly on September 30, 2012.

Strategy Accomplishment:

This strategy was partially achieved.

Objective 2.4. MHA will collaborate with CSAs and stakeholders to promote screening for mental health disorders, improve access and quality of PMHS services for individuals with co-occurring disorders, and provide linkages to appropriate treatment and supports across the life span.

(2-4A)

Continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment.

Indicators:

- Co-occurring disorders supervision collaborative training in eight outpatient mental health clinics (OMHCs)
- Training and consultation for substance abuse specialists on Assertive Community Treatment (ACT) teams
- Continued consultation for the Continuous Comprehensive Integrated System of Care

Involved parties: Carole Frank and Cynthia Petion, MHA Office of Planning, Evaluation, and Training; James Chambers, MHA Office of Adult Services; DHMH state program administrator for co-occurring disorders; Eileen Hansen and Tom Godwin, the University of Maryland Evidence Based Practice Center (EBPC); ACT teams; mental health providers

MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

FY 2011 activities and status as of June 30, 2011 (end of year report):

In the past, Maryland has emphasized cross training of staff and coordination of services as means of providing access to services for individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses.

MHA, in collaboration with the Alcohol and Drug Abuse (ADAA) and the Developmental Disabilities Administrations (DDA), co-sponsored a DHMH Supervisors' Academy. This Academy began in the spring of 2010, and ended April 2011. Twenty-

one supervisors/trainers from all three administrations participated in this yearlong interdisciplinary, train-the-trainer program consisting of monthly day-long sessions. In efforts to expand the process of the Academy, there were discussions of developing a Co-occurring Disorders Supervision Collaborative for eight supervisors from eight outpatient mental health centers. However, it was decided that such a process might confuse what is currently being implemented under DHMH which emphasizes cross-training between the three administrations. Therefore, it was important to look for a different process to support improved diagnosis capable (DDC) practices within the PMHS.

Over the past 18 months, the Mental Hygiene Administration (MHA) has worked toward the implementation of a work plan designed to increase the number of programs that are DDC. Six county jurisdictions, which have chosen to adopt the implementation of the Comprehensive, Continuous, Integrated System of Care model (CCISC), are in various stages of development. Assertive Community Treatment (ACT) teams are receiving training on interacting with substance abuse to improve the Dual Diagnosis Capability of each of the 10 ACT teams, on an individualized basis.

Additionally, the Evidence-Based Practice Center (EBPC) has continued to provide regional training sessions such as “Effective Screening and Assessment for Co-occurring Disorders”. During the FY 2011 round of training there were 346 attendees. MHA has also sponsored regional workshops on screening and assessment for substance abuse to encourage integrated treatment. These trainings are also open to all three administrations. In the coming year, each Core Service Agency (CSA) will have individual consultation to engage in a discussion about the best way to achieve dual diagnosis capability for their providers. The discussion will include how to ensure integrated care of the co-occurring population.

The Office of the DHMH Deputy Secretary of Behavioral Health and Disabilities continues to work toward the goal of expanding the development of a system of integrated services including co-occurring services of substance abuse and mental health.

Strategy Accomplishment:

This strategy was achieved.

Objective 2.5. MHA will closely monitor the activities of national and state health reform and prepare and plan, as necessary, appropriate coordination and collaboration.

(2-5A)

Improve communication, and efforts that support activities that lead to implementation of health reform and coordination of care, in the delivery of services to individuals with mental illnesses.

Indicator:

- Resource information on Health Reform legislation and information from Maryland's Health Care Reform Coordinating Council reviewed and disseminated to MHA, CSAs, providers, and other stakeholders

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Gayle Jordan-Randolph, MHA Office of the Clinical Director, Cynthia Petion, Office of Planning, Evaluation, and Training; MHTO; DHMH; CSAs, Center for Medicare/Medicaid Services (CMS); Medical Assistance or Medicaid (MA), other mental health consumer and family advocacy groups; CBH; other stakeholders

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordan-Randolph, MHA Office of the Clinical Director

FY 2011 activities and status as of 6/30/2011 (end-year report):

In response to the enactment of the Patient Protection and Affordable Care Act (PPACA), Maryland Governor Martin O'Malley created the Maryland Health Care Reform Coordinating Council (HCRCC) through an Executive Order to ensure that Maryland implements federal health care reform, thoughtfully and collaboratively across agencies and all branches of government, with meaningful participation of the health care community and other private sector stakeholders. The Council made policy recommendations and offered implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs.

The Council, initially co-chaired by Lt. Governor, Anthony Brown and former DHMH Secretary, John Colmers, was comprised of health leaders across the state. The Council's first milestone was the submission of an interim report to the Governor that included a timeline of legislative and regulatory changes necessary for implementation. The HCRCC had established workgroups, which were open to the public, on six identified areas of focus to address the full scope and complexity of the fundamental aspects of reform. The workgroups focus areas were:

1. Health Insurance Exchange and Insurance Markets
2. Entry Into Coverage;
3. Outreach and Education;
4. Public Health, Safety Net and Special Populations;
5. Health Care Workforce; and
6. Health Care Delivery System

The HCRCC issued a final report on January 1, 2011, which set forth a blueprint for well-planned and inclusive implementation of health care reform. The report contained many recommendations including: establishing a Health Benefit Exchange; improvement of coordination of behavioral health and somatic services; comprehensive workforce development planning; elimination of health disparities; development and incorporation of strategies to promote outreach, education, and access to high quality care for special populations; and establishment of a Governor's Office of Health Reform.

In April 2011 Governor O'Malley signed a law that established the Health Benefit Exchange. On May 26, 2011 he appointed a nine member board to oversee the Exchange. DHMH's Secretary, Joshua M. Sharfstein, M.D., will serve as a board member for the Exchange. That same day the Governor signed an executive order to establish the Governor's Office of Health Care Reform. In addition, he extended the term of the HCRCC through 2015. The HCRCC will continue to meet quarterly to monitor progress on implementation of recommendations. Information on Maryland's Health Care Reform was disseminated at MHA's State Plan Development meetings, conferences, and other venues.

Strategy Accomplishment:

This strategy was achieved.

GOAL III. WORK COLLABORATIVELY TO REDUCE THE IMPACT OF VIOLENCE AND TRAUMA FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND OTHER SPECIAL NEEDS.

Objective 3.1. MHA will protect and enhance the rights of individuals receiving services and promote the use of advance directives in the PMHS.

(3-1A)

MHA's Office of Forensic Services, in collaboration with the Mental Health & Criminal Justice Partnership (MHCJP) and the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, will continue to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system.

Indicators:

- Provider linkages established
- Access to services monitored and reported
- Minutes of meetings (IFSC and MHCJP) disseminated
- Recommendations presented

Involved Parties: Larry Fitch, Dick Ortega, and Debra Hammen, MHA Office of Forensic Services; Marian Bland and Darren McGregor, Office of Special Needs Populations; CSAs; Mental Health & Criminal Justice Partnership (includes: MHAMD and other state agencies); the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council
MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Mental Health and Criminal Justice Partnership (MHCJP) continues to work with corrections, mental health, substance abuse, consumer and advocacy groups, and other key stakeholders. The committee's primary mission is to identify and promote services that assist consumers who encounter the criminal justice system and divert them from correctional settings to community-based treatment.

MHA's Office of Forensic Services (OFS) staff participated in bi-monthly meetings of the MHCJP and in subcommittee meetings on training for law enforcement agencies. The committee's accomplishments in FY 2011 include:

- Monitoring a newly instituted system for the State's Motor Vehicle Administration to provide identification cards for inmates released from prison
- Working with the CSAs to assure aftercare appointments at community mental health clinics for former prison inmates with mental illnesses within 30 days of their release from prison
- Lobbying mental health, substance abuse, and correctional agencies to increase the availability of diversion services

- Monitoring the implementation of new legislation requiring the Department of Public Safety and Correctional Services to provide a 30-day supply of psychiatric medications to inmates released from prison

Strategy Accomplishment:

This strategy was achieved.

(3-1B)

The MHA Office of Consumer Affairs, in collaboration with the Core Service Agencies (CSAs), PMHS provider organizations, and the administrative services organization (ASO) will support the use of and increase access to advance directives by consumers in the PMHS.

Indicators:

- Advance Directives for mental health treatment promoted through On Our Own of Maryland (OOOMD) and Wellness & Recovery Centers; inclusion of advance directives information within WRAP trainings, also through the ASO and the Network of Care Web sites
- Partnership with ASO Manager of Prevention Education & Outreach to promote mental health advance directives during community education outreach activities

Involved Parties: Clarissa Netter, MHA Office of Consumer Affairs; MHA Office of Planning, Evaluation, and Training; state facility representatives; MHA Attorney General; ASO; CSAs; MHAMD; NAMI MD; OOOMD; CBH

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2011 activities and status as of 6/30/2011 (end-year report):

ValueOptions® Maryland, the administrative services organization for the Public Mental Health System, published a Consumer Handbook in 2011. Information on advance directives for mental health treatment (form and instructions) was included in reader friendly format. Ten thousand booklets were printed by ValueOptions® Maryland and widely distributed across the state including to Wellness & Recovery Centers. The On Our Own of Maryland, Inc. annual conference disseminated more than 3,000 booklets to attendees.

The Maryland Network of Care for Behavioral Health continues to operate as a Personal Health Record for its users as a valuable method to store and share personal health records in a secure Web environment. Collaboration continued among MHA, the Mental Health Transformation Office (MHTO), and CSAs, to more widely-inform the mental health community regarding availability of the Web system, and to train consumers in the utilization of personal health record features and in the use of individual advance directives.

Strategy Accomplishment:

This strategy was achieved.

(3-1C)

Provide information, training, and technical assistance for MHA facility staff, CSAs, and community providers regarding services for individuals who have mental illnesses and are involved with the criminal or juvenile justice system.

Indicators:

- Training provided on court evaluations and status reports
- Symposium held to include presentations to at least 250 DHMH-MHA facility staff, community providers, and other state agencies
- Technical assistance provided on services for individuals returning to the community

Involved Parties: Larry Fitch, Jo Anne Dudeck, Debra Hammen, and Dick Ortega, MHA Office of Forensic Services; Al Zachik and Marcia Andersen, MHA Office of Child and Adolescent Services; MHA facilities; CSAs; community providers; University of Maryland Training Center; Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

OFS staff met routinely throughout the year with Maryland facilities staff and community providers to disseminate information regarding juvenile competency and other forensic issues. In FY 2011, MHA's OFS staff also provided targeted training and technical assistance to these entities on a range of issues including diversion, services for justice-involved consumers in the community, community re-integration, and consumer concerns regarding the delivery of forensic services.

OFS staff participated in the following academic trainings in which clinical professionals received certificates:

- The fourteenth Annual Symposium on Mental Disability and the Law held on June 24, 2011 at the Pearlstone Conference Center in Reisterstown, Maryland. Two hundred professionals and consumers attended.
- The ninth Annual Juvenile Forensic Psychiatry Symposium, held August 25, 2011, for University of Maryland fellows and residents.

Additionally, the MHA Child and Adolescent staff provide training for Maryland Department of Juvenile Services (DJS) direct care staff on an as needed basis. The Office of Forensic Services (OFS) participated in regular meetings with the CSAs, local criminal justice and court officials, and other stakeholders to offer Mental Health Court Risk Assessment training and address services and evaluations for justice-involved consumers.

Strategy Accomplishment:

This strategy was achieved.

(3-1D)

Based on a 1987 Lisa L. Program class action lawsuit (which requires timely discharge from hospitals to appropriate placements), track and monitor children and youth in state custody in designated psychiatric hospitals as identified under Code of Maryland law (COMAR) 14.31.03.

Indicators:

- Hospital staff and providers trained on the on-line use of the Psychiatric Hospitalization Tracking System for Youth (PHTSY) - a Web-based module of the State Children, Youth, and Family Information System (SCYFIS)
- Regional trainings conducted for agency and hospital staff on the regulations governing interagency discharge planning for children and adolescents
- Reports generated utilizing information in PHTSY for hospitals and the Multi Agency Review Team (MART) agencies

Involved Parties: Musu Fofana and Marcia Andersen, MHA Office of Child and Adolescent Services; Governor's Office for Children; MHA inpatient adolescent unit and eight private hospitals; Multi-Agency Review Team (MART) Members (DDA, MHA, DJS, DHR and MSDE); Unit Managers, discharge coordinators, case managers, and social workers at participating inpatient psychiatric hospitals; providers

MHA Monitor: Marcia Andersen and Musu Fofana, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2011, training on the use of the Psychiatric Hospitalization Tracking System for Youth (PHTSY) continued for new hospital staff (discharge coordinators, social workers, etc.) at 10 psychiatric hospitals (private and state-operated).

The regulations governing interagency discharge planning for children and adolescents were updated to ensure relevance to current practices and protocols for placement of youth. Electronic access to resource information was completed in March 2011. Tracking of target population of youth was improved with more than 300 youth admitted to participating inpatient psychiatric hospitals.

Bi-weekly data reports and quarterly reports are submitted to unit managers and local agency representatives. Lisa L. status updates continue to be presented to the interagency team, hospitals, and local agencies through the use of quarterly progress reports.

Strategy Accomplishment:

This strategy was achieved.

Objective 3.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for children with emotional disabilities and individuals of all ages with psychiatric disorders and co-existing conditions including but not limited to: court and criminal justice involvement, deaf and hard of hearing, traumatic brain injury (TBI), homelessness, substance abuse, developmental disabilities, and victims of trauma.

(3-2A)

Facilitate community placements, ensure access to somatic and mental health services, and monitor plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver.

Indicators:

- Plans of care developed and monitored for approximately 60 TBI waiver participants
- Increased utilization of enhanced transitional case management to support program's expansion and increased enrollment
- Financial incentives identified to expand provider capacity
- Additional providers enrolled
- Eligible participants enrolled in Money Follows the Person Project (MFP), enhanced federal match spent on initiatives that increase community capacity

Involved Parties: Stefani O'Dea and Nikisha Marion, MHA Office of Adult Services; Medical Assistance Division of Waiver Programs; Coordinators for Special Needs Populations in MHA facilities; CSAs; TBI Advisory Board; community providers

MHA Monitor: Stefani O'Dea, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA is the lead agency in Maryland for current Traumatic Brain Injury (TBI) initiatives, which include a Home and Community-Based Waiver for individuals with TBI. In FY 2011, 58 individuals were served through this program and one new provider enrolled.

Of the 58 individuals, 15 were enrolled in Money Follows the Person Project (MFP), which utilizes home and community-based services (HCBS) waivers as the strategy for transitioning individuals from institutional settings to community-based services and enhances federal match spending on initiatives that increase community capacity.

MHA's TBI project staff continue to provide education and consultation to local mental health providers and other human service agencies on recognizing the signs of TBI and on strategies for affectively serving and supporting those individuals in the least restrictive setting. Additionally, MHA provides staff support to Maryland's TBI Advisory Board, which is legislatively mandated to report annually to the Governor and the General Assembly on the needs of individuals with TBI.

Strategy Accomplishment:

This strategy was achieved.

(3-2B)

Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, and other involved parties to implement standards identified by DHMH to enhance access to services that are culturally competent, clinically appropriate, and recovery-oriented for individuals who are deaf or hard of hearing.

Indicators:

- Development of standards completed; standards presented and publicized
- Standards implemented
- Council minutes and reports disseminated

Involved Parties: Marian Bland, MHA Office of Special Needs Populations; Iris Reeves, MHA Office of Planning, Evaluation, and Training; Marcia Andersen, MHA Office of Child and Adolescent Services; CSAs; ODHH; consumers and family advocacy groups; state and local agencies, colleges and universities; local service providers

MHA Monitor: Marian Bland, MHA Office of Special Needs Population

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA participated in all four quarterly Behavioral Health subcommittee meetings of the Maryland Advisory Council for the Office of Deaf and Hard of Hearing (ODHH). In FY 2010 the subcommittee drafted minimum criteria for providing behavioral health care for Marylanders who are deaf or hard of hearing and drafted recommendations to MHA's ASO regarding standards for public mental health providers certifying proficiency and cultural competency in serving deaf consumers. In FY 2011, the behavioral health subcommittee revised and resubmitted its recommendations to the Deputy Director of Behavioral Health and Disabilities and is awaiting final review and approval.

MHA continues to work with the ODHH Advisory Council and the CSAs to develop strategies to improve access to outpatient treatment and improve the competencies of outpatient providers working with consumers who are deaf or hard of hearing. Additionally, MHA provides technical assistance and advice to CSAs in addressing the needs of individuals who are deaf or hard of hearing.

In March 2011, MHA's Office of Special Needs Populations held a one-day conference "Helping Individuals to Lead Better Lives". The Governor's Office of Deaf or Hard of Hearing presented two afternoon workshops, which were well received, on cultural sensitivity and awareness for providers working with individuals who are deaf or hard of hearing. Additionally, in May 2010, MHA hosted a cultural sensitivity and awareness training for behavioral health providers, CSAs, consumers, and advocates on understanding issues faced by consumers who are deaf or hard of hearing.

Strategy Accomplishment:

This strategy was partially achieved.

(3-2C)

MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies, and selected local providers (local detention centers, hospitals and mental health clinicians) will partner with National Association of State Mental Program Directors (NASMHPD) and others to provide training and disseminate information regarding trauma-informed systems of care.

Indicators:

- Trauma-informed care training criteria established
- Provider sites selected
- Trainings scheduled and accomplished
- List of providers trained in trauma-informed care developed

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; CSAs; NASMHPD; local detention centers; hospital and mental health clinicians;

MHA Monitor: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

FY 2011 activities and status as of 6/30/2011 (end-year report):

In partnership with NASMHPD, MHA participated in trainings and presentations on trauma-informed care including Maryland's Trauma, Addictions, Mental Health, And Recovery (TAMAR) project, a program which provides treatment for incarcerated men and women who have histories of trauma and mental illnesses. In an effort to reach more individuals with trauma histories, MHA has standardized the TAMAR program and reached beyond local detention centers providing training and technical assistance to various agencies and venues. Also, a workshop on TAMAR was held in March 2011, at MHA's Office of Special Needs Populations one-day conference "Helping Individuals to Lead Better Lives".

Additionally, Maryland has developed several programs that involve trauma screening and trauma informed care as a component of standard care. These include: Chrysalis House/Healthy Start, a statewide diagnostic and transitional program for justice system involved, pregnant women as an alternative to incarceration; Seclusion and Restraint Reduction in MHA facilities; and Traumatic Brain Injury (TBI) training in collaboration with other agencies.

Through the Alcohol and Drug Administration's (ADAA's) training division, the Office of Education and Training for Addiction Services (OETAS), psychotherapists, social workers, addictions counselors and others in the behavioral health field have received training on trauma-specific services and trauma-informed care. Training and presentations have also been provided to local community mental health centers, residential treatment facilities, and local drug courts as well as national and international venues. During the Co-Occurring Disorders Supervisor's Academy, MHA conducted a training session to help participants understand how trauma impacts treatment and recovery and how to apply this knowledge in their assessment and treatment of individuals with co-occurring disorders. MHA actively collaborates with the Maryland's Department of Public Safety and Correctional Services through the Female Offender

Workgroup with program development and staff training on trauma informed care principles and the Task Force on Prisoner Reentry to further research and improve performance and outcomes.

The aggregate number of attendees for all FY 2011 presentations and trainings exceeded 500. Currently efforts are underway to further implement trauma-informed care in state facilities and other venues.

Strategy Accomplishment:

This strategy was achieved.

(3-2D)

Provide staff support for the Child, Family, and Special Populations Subcommittee of the Veterans Behavioral Health Advisory Board and technical assistance in identifying licensed behavioral health clinicians experienced in working with and providing services for veterans.

Indicators:

- MHA staff support provided for the subcommittee of the Board
- Minimum training requirements for certification identified
- Recommendations on certification presented
- Inventory of trained providers developed and available

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; Archie Wallace, DHMH; Maryland Lieutenant Governor Anthony Brown; Brian Hepburn, MHA, Office of the Executive Director; Pro Bono Counseling Project; U.S. Department of Veterans Affairs; Maryland Department of Veterans Affairs; Maryland National Guard; Maryland Defense Force; Veterans Behavioral Health Advisory Board; advocacy organizations

MHA Monitor: Marian Bland, MHA Office of Special Needs Populations

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA's Office of Special Needs Populations staffed the Maryland Commitment to Veterans – Children, Family, and Special Populations subcommittee of the Veterans Behavioral Health Advisory Board. The final report of the Veterans Behavioral Health Advisory Board was submitted in January 2011 and addressed, among its 14 recommendations, areas of counseling, support services, mental health, and workforce credentialing with recommendations such as:

- Graduate students studying sociology, psychology, social work, marriage and family therapy, and other forms of counseling services governed by state licensure could be trained as subject-matter experts to support the emotional needs of military children and families via internships

- Maryland Department of Veterans Affairs (MDVA) should establish special initiatives to promote awareness of the needs of women Veterans, including: mobilizing women's advocacy groups to develop counseling and other supportive services; and hosting a Women's Veterans Conference that would include offering training modules for behavioral health services providers
- Promote opportunities for incarcerated Veterans (at Maryland state and county correctional facilities) to have access to evidence-based behavioral health services focused on Veteran populations and behavioral health conditions related to military service and combat exposures; training for the correctional and forensic workforce will also be necessary
- Identify the mental health practice skill requirements related to serving Veterans and their family members and initiate public/private collaborations to address them
- Consider establishing specialized certification that would identify Maryland behavioral health providers who have the requisite credentials to serve the needs of returning Veterans and their family members; a program that already exists in North Carolina could serve as the model for a Maryland certification program

Other recommendations addressed community outreach, education, and awareness; partnerships with schools, advocacy organizations and non-profit agencies; and media resources. The entire report, including other sub-groups associated with the Maryland's Commitment to Veterans Initiative, can be accessed on line at www.msa.md.gov and search for Maryland's Commitment to Veterans.

The Advisory Board, as mandated through Maryland legislation requirement, no longer meets. However, local counties such as Montgomery are convening Veterans Collaboratives. Data has identified that in FY 2010, 1,058 veterans have been served in the PMHS and in FY 2011, 794. Data regarding veterans served specifically through the PMHS will be further explored through these local groups.

Strategy Accomplishment:

This strategy was achieved.

(3-2E)

MHA, in collaboration with the Committee on “Aging in Place”, will develop an integrated care model for consumers age 50 years and over with behavioral and somatic health needs in PMHS residential programs.

Indicators:

- Activities of the “Aging in Place” committee expanded to include additional provider input
- Cost analysis developed, assessment tools selected, jurisdictions determined
- Components of integrated care model identified; recommended model developed

Involved Parties: James Chambers, Marge Mulcare, Penny Scrivens, and Georgia Stevens, MHA Office of Adult Services; Jim Macgill, MHTO; Committee on Aging in Place; DHMH Office of Health Services; Office of Health Care Quality (OHCQ); CSAs; the Mental Health Association of Maryland (MHAMD); CBH
MHA Monitor: James Chambers, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Aging in Place Committee has moved forward in FY 2011 to finalize identification of a model of integrated care ready for Medicaid funding that will address the somatic needs of older adults living in residential rehabilitation programs (RRPs) with added provisions for consumers served on the inpatient units. Nurses from the Developmental Disabilities Administration (DDA) completed an evaluation using the Physical Status Review Health Risk Screening Tool (HRST) developed to determine level of care needed to support consumers living in RRP. Most of the information was coordinated in collaboration with the Mental Health Transformation Office and submitted for final review to MHA leadership.

The results of these reviews will assist in the finalization of an appropriate model that can be replicated and sustained within existing budgetary constraints yet address the clinical needs of older individuals in RRP and inpatient settings.

Strategy Accomplishment:

This strategy is partially achieved.

Objective 3.3 MHA, in collaboration with CSAs, consumer and family organizations, governmental agencies, the administrative services organization (ASO), and other stakeholders, will address issues concerning improvement in integration of community services.

(3-3A)

Continue to monitor crisis response systems, hospital diversion activities, and community aftercare services to increase the diversion from inpatient hospitalization and detention center utilization by individuals with mental illnesses.

Indicators:

- Number of uninsured individuals diverted from emergency departments, state hospitals, other inpatient services, and detention centers
- Number of alternative services provided
- Reduction of emergency department requests for admission to state hospitals
- Service continuum plan developed

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; James Chambers, MHA Office of Adult Services; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Facility CEOs; Larry Fitch, MHA Office of Forensic Services; Alice Hegner, MHA Office of CSA Liaison; Randolph Price, MHA Office of Administration and Finance; CSA directors in involved jurisdictions; Baltimore Crisis Response; Baltimore Mental Health Systems; other stakeholders

MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

FY 2011 activities and status as of 6/30/2011 (end-year report):

The implementation of the hospital diversion activities in several counties and the increase in purchase of care (POC) beds have contributed to expanded access to community-based inpatient services and decreased civil admissions to state facilities. Additionally, in FY 2010, CMS clarified the Emergency Medical Treatment and Labor Act (EMTALA) policy for receiving hospitals. Based on this policy, hospitals and emergency departments cannot turn down an admission because the individual is uninsured. This assists the EDs to more quickly move people through their systems.

In FY 2011, Anne Arundel and Montgomery counties and Baltimore City, the jurisdictions initially in MHA's hospital diversion pilot program, continue to facilitate the diversion of people to less intense level of alternative or community-based services (data is no longer regularly submitted to MHA but is available at the local level). The number of individuals in need of diversion from hospital EDs has decreased from previous years but this can be attributed to EMTALA and the overall decrease in the need for services. The number of emergency department requests for admission to state hospitals has been reduced. In collaboration with all CSAs across the state, MHA promotes the use of alternative services to hospital levels of care and facilitates the discharge of long-stay state hospital patients. The PMHS offers several services that can prevent an inpatient psychiatric admission or provide an alternative to psychiatric inpatient admissions. These services include Mobile Treatment (MT) Services and Assertive Community Treatment

(ACT). Also, crisis response programs are promoted within their jurisdictions through the Core Service Agencies and continue to offer services at capacity.

Other local efforts toward judicial diversion services continue. Carroll and Harford counties have mental health diversion programs and Calvert, Mid-shore, and Prince George's counties support a liaison between the jail and the courts to recommend community-based mental health services as a diversion to detention or incarceration. In addition to working with the counties, MHA continues to partner with Baltimore City CSA to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). FAST also diverts individuals from jail and connects them to services.

Strategy Accomplishment:

This strategy was achieved.

(3-3B)

In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 80 children and youth and their families in four jurisdictions across the state.

Indicators:

- Number of Waiver providers enrolled, (including youth and family peer support providers)
- Number of youth enrolled, program monitored

Involved Parties: MHA Office of Child and Adolescent Services; Maryland Child and Adolescent Mental Health Institute; MA; CSAs; Maryland Coalition of Families for Children's Mental Health; Maryland Association of Resources for Families and Youth (MARFY); Governor's Office for Children (GOC); the Children's Cabinet; Local Management Boards (LMBs)

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA continued implementation of the Centers for Medicare and Medicaid (CMS) sponsored psychiatric residential treatment facility (PRTF) demonstration, which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. MHA is beginning work to continue offering services to children, adolescents, and transition-age youth (TAY) currently available under a 1915(c) PRTF Demonstration Waiver.

Current enrollment as of the end of FY 2011 was 138 individuals. There are currently 31 enrolled providers of specialized waiver services, with many of these providers offering more than one type of waiver service.

The waiver is guided by a federally required Quality Assurance Plan which was implemented this year with discovery and plans of correction. A serious incident reporting mechanism has been established and is producing useful quality improvement information.

The PRTF Demonstration Project will end in September 2012 for new admissions and, as a result, the State of Maryland is actively involved in a major project to sustain and expand the infrastructure created under the PRTF demonstration waiver.

Strategy Accomplishment:

This strategy was achieved.

(3-3C)

Review, revise and amend Maryland's Medicaid State Plan for community mental health services.

Indicators:

- Proposals developed to add peer support services, supported employment, and crisis services
- State plan request submitted to CMS
- Public notice provided

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Brian Hepburn, MHA Office of the Executive Director; James Chambers and Penelope Scrivens, MHA Office of Adult Services; Alice Hegner, MHA Office of CSA Liaison; Randy Price, MHA Office of Administration and Finance

MHA Monitor: Melissa Schober, MHA Medicaid Policy Analyst

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA adopted regulations for telemedicine and received approval, on June 13, 2011, for Medicaid reimbursement from the Centers for Medicare and Medicaid (CMS) for telemental health services provided in rural/underserved counties.

MHA is proceeding with efforts to develop amendments to the Medicaid State Plan for PRP rate change, peer support, supported employment, and crisis residential and mobile crisis mental health services. As a first approach to this process, MHA has convened several workgroups comprised of consumers, providers, and other stakeholder groups to examine each service. MHA is in the final stages of writing a 1915(i) state plan amendment to revise cost methodology for psychiatric rehabilitation services. Also, in light of interdepartmental efforts with ADAA to align regulations and services, where possible, the MHA-convened work group on Medicaid and Crisis Services has temporarily stopped meeting and plans to reconvene in 2012. The Work Group has drafted preliminary regulatory language but wants to ensure the inclusion of the needs of co-occurring individuals before proceeding further.

Additionally, in October 2011, MHA (in conjunction with the State Medicaid Agency) will submit an application for the Medicaid Emergency Psychiatric Demonstration Project. The Demonstration was part of federal health reform (section 2707 of P.L. 111-14). If selected, Maryland would receive federal match (FFP) for consumers between 22-64 years of age receiving inpatient psychiatric care in private Institutes of Mental Disease (IMDs) from FY 2012-2015.

Strategy Accomplishment:

This strategy was partially achieved.

GOAL IV. PROVIDE A COORDINATED APPROACH TO INCREASE EMPLOYMENT AND PROMOTE INTEGRATION OF SERVICES AND TRAINING TO DEVELOP AND SUSTAIN AN EFFECTIVE BEHAVIORAL HEALTH WORKFORCE.

Objective 4.1. MHA, in collaboration with CSAs and state agencies, will develop employment options and supports to increase the number of consumers employed.

(4-1A)

Continue to implement the Maryland Mental Health Employment Network (MMHEN), a consortium of Maryland mental health supported employment providers and CSAs, to increase and enhance the array of choices of supported employment services available by utilizing Social Security Administration incentives such as Ticket-to-Work.

Indicators:

- Continue administrative infrastructure and operation of MMHEN at Harford County Office on Mental Health (the CSA)
- Data reported on number of programs participating and consumers receiving training in these programs
- Number of consumers receiving individual benefits counseling in the Ticket-to-Work Program

Involved Parties: Steve Reeder, MHA Office of Adult Services; Division of Rehabilitation Services (DORS); CBH; OOOMD; CSAs; NAMI MD; University of Maryland Training Center; ASO

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA, in collaboration with the Social Security Administration (SSA), Maryland State Department of Education-Division of Rehabilitation Services (MSDE-DORS), the Harford County Core Service Agency (CSA), and the evidenced-based supported employment providers, continued its demonstration project under the auspices of the Ticket-to-Work (TTW) regulations. MMHEN served eighty individuals in the program in FY 2011.

MMHEN provides administrative, marketing, and technical support to five providers. Participating providers are Alliance, Goodwill STEP, Mosaic, Humanim, and St. Luke's House. The project is located in the Harford County Office on Mental Health.

In July 2010, the ASO, ValueOptions® Maryland, began work to integrate TTW and employment network information in the ASO's authorization system and continues to work with MMHEN to make data available through its integrated Web-based platform. A data base system that has been specifically designed for Ticket-to-Work data management is in the final stages of development. This will allow MMHEN to collect additional outcome data and to identify trends. Infrastructure for this program has been

developed through enhanced computer hardware and plans to integrate the unemployment insurance earnings records within the ASO's authorization and data system, thus providing SSA with the necessary wage information without having to track individual ticket holders. MHA worked with SSA in order to have this flexibility in the Maryland model. Wage information and TTW details are tracked monthly by the Harford County CSA by data extract and provider contact. Provider meetings take place quarterly.

The MMHEN partners with OOOMD to provide benefits counseling to consumers so they understand SSA's work incentives and protections. The TTW specialist is also training to be a Work Incentive Coordinator. The MMHEN has joined the National Employment Network Association and also works closely with SSA to stay informed about national developments as well as ways to expand and improve services. In FY 2012, MHA will explore expanding the MMHEN to include transition-age youth and/or other individuals with mental illness who are in need of employment supports.

Strategy Accomplishment:

This strategy was achieved.

(4-1B)

Convene at least two educational seminars on work incentives to assist consumers with mental illnesses to return to work and retain access to needed benefits and health insurance.

Indicators:

- Educational seminars on work incentives delivered to providers, consumers, and other mental health stakeholders
- Number of seminar participants

Involved Parties: Steve Reeder, MHA Office of Adult Services; Carole Frank, MHA Office of Planning, Evaluation, and Training; DORS; Maryland Department of Disabilities (MDOD); Work Incentives Planning and Assistance (WIPA) Project; CSAs; CBH; OOOMD; NAMI MD; University of Maryland Evidence-Based Practice Center (EBPC)

MHA Monitor: Steve Reeder, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA and NAMI Family Advocacy Team have provided two full-day workshops for providers, consumers, and family members on SSI/SSDI Benefits Counseling. In April 2011, a full-day workshop on benefits training and work incentives was held for SE staff and ACT Team Leaders. The training took place at the Department of Transportation and was attended by 42 participants. In May 2011, 25 consumers and family members attended a full-day workshop. The workshop was interactive and many expressed appreciation of learning about the possibility of utilizing work incentives without losing insurance benefits.

Additionally, MHA and NAMI provided a 30-minute teleconference on the core principles of SE (now posted on the NAMI MD Web site), as well as multiple presentations to families, consumers, and providers on the valuable role employment has in recovery from mental illness. MHA also works with OOOMD to include provider-specific and consumer-focused workshops on the Employed Individuals with Disabilities (EID) program as a component of its educational and counseling initiatives.

Strategy Accomplishment:

This strategy was achieved.

Objective 4.2 MHA will develop and implement collaborative training initiatives involving other agencies and stakeholders serving individuals with psychiatric disorders in the PMHS.

(4-2A)

Continue to enhance workforce development through the incorporation of peers into the workforce through the involvement of the following: Peer Employment Resource Specialist (PERS) Training, Maryland Association of Peer Support Specialists (MAPSS), Maryland Consumer Leadership Coalition, and Maryland Consumer Volunteer Network.

Indicators:

- Development and implementation of curriculum for MAPSS training manual
- Development and support of training to support increased employment of peers in the workforce
- Implementation of PERS training in various regional settings
- Potential use of Network of Care Web site to identify workforce development issues and career opportunities

Involved Parties: Clarissa Netter, MHA Office of Consumer Affairs; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; OOOMD; CBH; MHTO; Sar Levitan; Johns Hopkins University; other mental health advocacy groups; peers organizations

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Maryland Consumer Leadership Coalition (MCLC) continues to function with quarterly meetings and has begun to address membership expansion and issues relevant to consumers with co-occurring issues.

The Maryland Association of Peer Support Specialists (MAPSS), created to train and implement the Certification of Maryland Peers, is non-functional at this time and is expecting to continue in the future under the auspices of OOOMD rather than become a 501c3. The Maryland Consumer Volunteer Network is continuing to increase leadership skills and create workforce development initiatives throughout the system and will work to upgrade computer technology in FY 2012 to give access to a variety of programming opportunities including the use of Network of Care as a resource.

The work of MCLC continues to enhance the incorporation of peers into the workforce through Peer Employment Resource Specialist (PERS) training taking place in several regional settings throughout the state. Additionally, in FY 2011, there were two PERS follow-up trainings for consumer participants in Baltimore City. To date there have been 86 consumers across the state who have graduated from the PERS program.

In the summer of FY 2012, follow-up PERS training sessions will take place specifically for PERS graduates addressing employability, development planning, and job development.

Additionally, efforts through Sar Levitan/MCLC to implement PERS curriculum in cooperation with two community colleges within the Maryland Community College system will provide opportunities for peers to work and simultaneously earn credits towards an Associate's Degree.

Strategy Accomplishment:

This strategy was achieved.

(4-2B)

Expand skills-based training opportunities to include Motivational Interviewing and Person Centered Planning to increase the effectiveness of service delivery within the PMHS.

Indicators:

- Number of Motivational Interviewing trainings given to providers
- Number of Person Centered Planning trainings held for consumers and providers
- Number of participants trained
- Pre/post test, anecdotal evidence of skill improvement

Involved Parties: University of Maryland Training and Evidence Based Practice Centers; Carole Frank and Cynthia Petion, MHA Office of Planning, Evaluation, and Training; James Chambers, MHA Office of Adult Services; consumers and mental health providers

MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA continues efforts to promote skill-based client-centered opportunities.

Motivational interviewing (MI) is considered to be an approach that is both client-centered and semi-directive with the goal of helping clients move toward change successfully and with confidence. Skill improvement has been evident through class exercises, evaluations, and anecdotal reports for about 275 participants in motivational interviewing sessions in 2011. Trainings in MI included: four day sessions for 220 individuals on-site in agencies provided by two Motivational Interviewing Network of Trainers' (MINT) certified instructors; one four-session training for 25 Employment Specialist and their supervisors from all over the state provided by MHA; one session for 20 Clifton T. Perkins Hospital Center social workers; and two sessions for People Encouraging People (PEP) provided by MHA.

Person centered planning or person centered care (PCC) is designed to enable people to direct their own plan for services and supports and is in concert with MHA's emphasis on a recovery-oriented and person-centered system of care. More than 600 family members, consumers, providers, educational staff, providers of services to older adults, and other clinicians have received at least one training on PCC. A brochure has been created explaining the use of PCC principles in supporting older adults, and PCC materials have been customized for providers of service to individuals with brain-injuries.

A national expert provided consultation, technical assistance, and two train-the-trainer sessions to a core group of 10 peer support specialists/peer advocates, Evidence-based Practice Center (EBPC) trainers, and several providers/staff in specialty areas such as; evidence-based practices, Traumatic Brain Injury waiver, co-occurring (including mental health with developmental disabilities or with substance abuse), and aging. Twenty participants attended. As a result:

- The Peer Support Specialists now work with consumers on ACT teams to prepare them to be active participants in their treatment planning processes. Further trainings from the consultant to the master trainers and Peer Support Specialists on ACT teams will be offered in the coming year. Additionally, the Director of the MHA Office of Consumer Affairs coordinates training with the consumer trainers selected from the ACT teams. Consumers who are master trainers on ACT teams provide PCC information to consumers served by those teams.
- Additionally, ASO staff are being trained on the implications of utilization review and medical necessity determination within a person centered planning framework.

Strategy Accomplishment:

This strategy was achieved.

(4-2C)

The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue development and delivery of curricula for training of staff in child mental health professions based on established core competencies.

Indicators:

- New training modules developed and marketed for undergraduate and graduate-prepared individuals to receive continuing education units (CEUs) via Web-based educational technology; number of individuals completing modules
- Certificate programs in specialized staff concentrations designed and marketed for undergraduate and graduate-prepared individuals
- Modules refined for utilization in existing master's degree programs (such as the University of Maryland School of Social Work) and for award of CEUs via Web-based technology
- Retention and Recruitment Plan developed and prioritized for implementation
- Mental health training model for educators developed to assist them in working with children, and their families, with mental health needs

Involved Parties: MHA Office of Child and Adolescent Services; MSDE; the Maryland Child and Adolescent Mental Health Institute; professional schools representing higher education; the Maryland Coalition of Families for Children's Mental Health; provider agencies; local school systems

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

In an effort to address the increasing need for qualified professionals and paraprofessionals to serve children with mental health needs and their families, DHMH, in collaboration with the Maryland State Department of Education (MSDE), convenes the Maryland's Child and Adolescent Mental Health Workforce Development Steering Committee. It is comprised of 50 members that include consumers, families, trainees, representatives of state and local agencies, higher education, public and non public schools, and providers of services. The MSDE Division of Special Education/Early Intervention Services and the Maryland State Department of Health and Mental Hygiene (DHMH) Mental Hygiene Administration developed new training modules, delivered via Web-based educational technology, with input from the Maryland Interdisciplinary Mental Health Workforce Committee. On this site, <http://mdvtc.umaryland.edu/TrainingAreas/CoreCompetencies.aspx>, baseline training is provided in the following content areas:

1. Child Development and Disorders
2. Youth and Families as Partners
3. Screening, Assessment, and Referrals
4. Treatment Planning and Service Provision
5. Outcomes and Quality Improvement
6. Behavior Management
7. Health and Safety
8. Community Development
9. Communication

These trainings were designed to be applicable to mental health professionals across specializations, including schools, child welfare, juvenile services, developmental disabilities, and early childhood. Also, mental health professionals working with children and youth with mental health needs and their families, individuals working in schools, clinics, in-home services, inpatient and residential programs, and other community settings are encouraged to participate in these trainings. This site allows participants to print a Certificate of Completion or CEUs after passing the quizzes and provides online feedback following the presentation.

The Committee is in the process of working on core competencies for teachers. Recruitment and Retention Plan implementation is in progress.

Strategy Accomplishment:

This strategy was achieved.

(4-2D)

MHA, in collaboration with CSAs, will provide training for law enforcement officers, first responders, corrections personnel and other public safety officials regarding the management of crises involving individuals who appear to have a mental disorder and are charged with offenses or suspected of criminal involvement or juvenile delinquency.

Indicators:

- Training curriculum updated
- A minimum of four trainings completed

Involved Parties: Larry Fitch and Dick Ortega, MHA Office of Forensic Services; CSAs; the Training Sub-committee of the Mental Health Criminal Justice Partnership; local and state police; detention center staff; sheriffs' office staff

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2011, MHA, in collaboration with law enforcement agencies and local crisis response systems, offered four police trainings regarding the management of crises involving persons suspected of committing an offense who appear to have a mental illness. These trainings on *Responding to the Person with Mental Illness and the Emergency Petition for Police Officers* were held at the Baltimore Police Academy in Baltimore City and were conducted by MHA's Office of Forensic Services. A total of 151 police personnel were trained.

These trainings, one segment of many statewide and local efforts to educate police and other first responders, addressed the use of emergency petitions, approaching persons with mental illnesses, the field interview of a person with a mental illness, dealing with the suicidal individual, individuals with post-traumatic stress disorder (PTSD), and treatment resources for active duty personnel and veterans. Presentations focused on the practical decisions that police officers have to make in the field and were delivered in plain, non-technical language. The presentations are continuously updated by MHA to reflect recent developments in the law and best practices.

Strategy Accomplishment:

This strategy was achieved.

Objective 4.3 Develop initiatives that promote the delivery of culturally competent and ethnically appropriate services.

(4-3A)

MHA will develop cultural competence training curricula for selected provider agencies within the PMHS.

Indicators:

- Incorporation of data from cultural competency assessment tool in curricula development
- Trainings provided to selected provider agencies on cultural and linguistic issues and system issues with additional emphasis, where appropriate, on regional and geographic differences
- A shorter two-hour orientation cultural competence training curriculum developed

Involved Parties: Iris Reeves, MHA Office of Planning, Evaluation, and Training; MHA Cultural Competence Advisory Group; MHA Office of Consumer Affairs; MHTO; CSAs; Cultural and Linguistic Competence Training Initiative Provider Agency Teams; consumer and family advocacy groups

MHA Monitor: Iris Reeves, MHA Office of Planning, Evaluation, and Training

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2010, MHA and the Mental Health Transformation Office (MHTO) developed a training manual and implemented the Cultural and Linguistic Competence Training Initiative (CLCTI), which included a five-day pilot training designed to assist organizations in Maryland with the incorporation of cultural and linguistic competence as an integral part of their organizational structure and operation. At the end of the training and into FY 2011, consultation/technical assistance sessions have been held with each CLCTI Leadership Team. These sessions have allowed each leadership team member to provide feedback related to the trainings and the resulting changes that are occurring within their programs and identify technical assistance needs or additional issues that needed to be addressed. The teams from each program identified 3 – 5 goals to be accomplished over a 9 -12 month period of time such as seeking further feedback from consumers on how to make the program more culturally competent, development of a community resource directory, or development of a more welcoming space in the treatment areas to reflect the cultural and ethnic attributes of the board, staff, consumers and the community at large.

Following individualized meetings with the programs, a shorter version of the training was developed on specific areas and needs that gave recognition to the geographic and cultural differences of each program. For example, some sessions, as a result of issues identified by consumers, focused on individuals who are gay, lesbian, transgender or questioning and appropriate situations of incorporation of spirituality into the clinical and treatment programs. In order to address these issues and others, the program providers asked to extend the CLCTI training to staff and consumers within their respective programs through the shorter 2-3 hour trainings for the staff and board members of the selected sites.

During consultation/technical assistance, agency specific reports were compiled which provided information on perceptions about the agency's commitment and efforts related to recovery and cultural and linguistic competence. These reports were utilized by the CLCTI consultants and the leadership team to identify additional issues that needed to be addressed. In addition to gathered information and self/organizational assessments, the cultural competency assessment tool, developed by MHA Cultural Competence Advisory Group to evaluate consumer and staff perception of cultural competence of providers/programs, was used and the findings summarized within these agency-specific reports.

Since the inception of the CLCTI Project, more than 300 individuals have received, at a minimum, the 2-3 hour CLCTI training which has been well received. The initiative has led the leadership teams, management, staff, and consumers to have a better understanding of cultural norms and beliefs and their influence on the health and well being of consumers. Each of the selected provider agencies for the CLCTI has been instrumental in assisting with moving the strategy forward. For example, one agency, based in Prince Georges County has ensured that each of the sites, under its umbrella, receives the training and has been integral to the success of the CLCTI.

Strategy Accomplishment:

This strategy was achieved.

(4-3B)

MHA, in collaboration with the DHMH Office of the Deputy Secretary of Behavioral Health and Disabilities and other stakeholders, will participate in the development and implementation of Maryland's Action Plan to Eliminate Disparities in Behavioral Health Care.

Indicators:

- Participation in Maryland's Policy Summit to Eliminate Disparities in Behavioral Health Care Workgroups
- Action Plan developed

Involved Parties: Brian Hepburn, Iris Reeves, and other MHA staff; DHMH Office of the Deputy Secretary; National Policy Summit to Eliminate Disparities in Behavioral Health Care Workgroup delegates; DHMH Office of Minority Health and Health Disparities; ADAA; DDA; CSAs; consumer, family, and provider groups;

Monitor: Iris Reeves, MHA Office of Planning, Evaluation, and Training

FY 2011 activities and status as of 6/30/2011 (end-year report):

Under the leadership of the DHMH Deputy Secretary for Behavioral Health and Disabilities, Maryland participated in a SAMHSA-sponsored policy academy on health disparities for behavioral health. The Workgroup is in the process of developing a framework for an action plan for Maryland that would support DHMH's vision of cross-cultural integration of services across the three administrations – Mental Hygiene, Alcohol and Drug Abuse, and Developmental Disabilities.

In FY 2010, a draft action plan was distributed to workgroup members. Three key areas have been identified for further development – data approaches, tactical approaches, and organizational approaches. Due to efforts and activities related to Maryland's implementation of Health Care Reform and behavioral health integration, activities associated with the development of an action plan have been redirected.

Strategy Accomplishment:

This strategy was partially achieved.

GOAL V. BUILD PARTNERSHIPS TO INCREASE THE PROVISION OF AFFORDABLE HOUSING AND REDUCE BARRIERS TO ACCESS IN ORDER TO PREVENT HOMELESSNESS FOR INDIVIDUALS WITH MENTAL ILLNESS.

Objective 5.1. Evaluate and develop opportunities to maximize current resources to promote affordable safe housing for individuals with serious mental illness.

(5-1A)

Continue to work with other state and local funding resources to promote and leverage DHMH's Administration-Sponsored Capital Program grant (Community Bond) funds to support an array of affordable and integrated housing choices for individuals with serious mental illness (SMI).

Indicators:

- Community bond housing applications approved to increase funding for supported and independent housing units
- Meetings with participating providers and non-profit organizations held
- Capital projects implemented

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHTO; Robin Poponne, MHA Office of Planning, Evaluation, and Training; Marian Bland, MHA Office of Special Needs Populations; DHMH Office of Capital Planning, Budgeting, and Engineering Services; CSAs; Maryland Department of Housing and Community Development (DHCD); MDOD; Developmental Disabilities Administration (DDA); Maryland Department of Aging (MDoA); Centers for Independent Living (CILS); local housing authorities; housing developers; Consultant Staff – TAC

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA's priority for Administration-Sponsored Capital Program grant (Community Bond) financing is the development of affordable housing projects. The Maryland General Assembly approved a total of \$4.8 million for FY 2011 to serve individuals with mental health needs, by providing new housing options under this program. In previous years, the Community Bond program provided funding toward housing for more than 525 individuals. Initiated in 2010 and implementation underway in 2011, a collaborative community bond effort among Springfield Hospital Center, Housing Unlimited, Inc. (HUI), and the Montgomery County CSA has the goal to transition 20 Springfield Hospital Center patients over two years into residential rehabilitation programs (RRPs) and have RRP consumers move into supported housing through HUI. Funding to match the Community Bond award came from Springfield Hospital Center budget to offer rental assistance to tenants moving into HUI units. The CSA and providers are working with a specific list of patients for placement into the RRP.

Also, MHA's strong interagency collaboration with the Department of Housing and Community Development (DHCD) and the Department of Disabilities (MDOD) has resulted in increased housing options for consumers of behavioral health services. The collaboration with other state agencies has resulted in looking at tax credit units that are developed throughout the state with set aside units specifically for persons with disabilities. In May 2011, an announcement was made by Governor Martin O'Malley about efforts between DHCD, Weinberg Foundation, and DHMH to fund non-profit developers with capital financing to offer housing units to persons at SSI and SSDI level of income.

In addition, state funding through DHCD encourages ongoing contact with 34 RRP providers to consider supported housing projects for the coming year in collaboration with local and state administered funding such as HOME and the HUD Community Development Block Grant (CDBG).

Finally, MHA conducts an ongoing group with RRP providers, CSAs, and state hospitals to reduce the number of vacancies in the RRP, identify ways to in-reach (providers come to meet and educate patients about their services) with patients in the hospital by offering access to resources such as, marketing services and manuals to support community placement efforts. Supported Housing providers, as well as a few developers applying for tax credits through DHCD, are working on blended funding and resources already established in the community to serve individuals coming out of the state hospitals or stepping down from RRP.

Strategy Accomplishment:

This strategy was achieved.

(5-1B)

MHA, in collaboration with CSAs, federal Department of Housing and Urban Development (HUD), local public housing authorities (PHAs), and other federal, state, and local entities, will work with housing infrastructures to improve and increase the number of housing options and funding opportunities for rental assistance for individuals with mental illnesses.

Indicators:

- Number of individuals who moved from state hospitals to residential rehabilitation programs (RRPs) and/or to independent housing
- Increased availability of vouchers through Money Follows the Person Initiatives; the Non-Elderly Disabled HUD Notice of Funds Availability (NOFA), and collaboration with local PHAs
- Increased access to funding through the American Recovery and Reinvestment Act (ARRA) and HOME Investment Partnerships Program
- RRP provider training continued on the needs of individuals with forensic involvement
- Collaboration with community-based entities

Involved Parties: Penny Scrivens, MHA Office of Adult Services; Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; CSAs; DHCD; MDOD; DDA; MDoA; CILS; local housing authorities; housing developers

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA participates in working with a steering committee – Maryland Partnership for Affordable Housing (MPAH) Advisory Group – chaired by MDOD and Money Follows the Person representatives, to implement the changes within the HUD 811 program in preparation for the HUD Notice of Funds Availability (NOFA), which are posted throughout the year for HUD projects.

An estimated 211 individuals moved from the hospital to RRP across the state during 2011. MHA participates in an ongoing interagency group meeting every other month to access vacancies, identify ways to in-reach, monitor barriers, access resources to assist with benefit applications, deliver Supplemental Social Security, Outreach, Access, and Recovery (SOAR) training, and conduct training for providers on working with individuals with forensic needs. Case management and other agencies assist individuals with disabilities to look for accessible and affordable housing in Carroll, Baltimore, Montgomery, and Howard counties, as well as Baltimore City, to utilize the non-elderly disabled (NED) vouchers (Category I and II) for persons who cannot access affordable housing in senior-only buildings.

The number of individuals leaving the hospital has increased since outreach with providers has started and collaboration with clinics and other community-based resources have improved. Ongoing partnerships with PHAs and other housing programs have assisted with helping individuals to step down from their placement in the community to more independent housing.

American Recovery and Reinvestment Act (ARRA) and HOME Investment Partnerships Program funds have been used by Departments of Social Services to offer one time only help to tenants accessing monies for security deposits, turn on fees for utilities, as well as rental subsidies in some jurisdictions.

Under a Memorandum of Understanding, the Weinberg Foundation and state agencies will work together to finance affordable, quality, independent, integrated housing opportunities for persons with very low income who have disabilities and meet certain eligibility criteria. The Weinberg units will house non-elderly individuals with disabilities at 15-30% AMI (Area Median Income) who pay 30% of their income for rent. Work with local public housing authorities will continue to help secure access to and stability in housing for consumers.

Strategy Accomplishment:

This strategy was achieved.

Objective 5.2. Continue to work collaboratively with appropriate agencies to improve access to mental health services for individuals who are homeless.

(5-2A)

Utilize Projects for Assistance in Transition from Homelessness (PATH) funding and the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative mechanisms for outreach, the prevention of homelessness, and the promotion of recovery for individuals who have mental illnesses.

Indicators:

- Utilization of increase in PATH funding to expand services to all areas of the state
- Outreach services provided to individuals who are homeless
- SOAR training and technical assistance provided to CSAs and providers of PATH, housing, or other services and supports to individuals who are homeless
- Expedited access to Supplemental Security Income/ Social Security Disability Insurance (SSI/SSDI) benefits and supports statewide
- Use of one time rental assistance to prevent homelessness
- Data gathered on number of individuals who are homeless assisted with applying for SSI/SSDI benefits
- Additional funding approved

Involved Parties: Marian Bland and Keenan Jones, MHA Office of Special Needs
Populations; other MHA staff; CSAs; PATH service providers

MHA Monitor: Marian Bland and Keenan Jones, MHA Office of Special Needs
Populations

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2011, MHA continued to expand the SOAR initiative. During this reporting year, SOAR has been implemented in three new sites: Carroll, Howard, and Montgomery counties. In addition to the existing work groups in Baltimore City, Anne Arundel, Prince George's, and the Lower Eastern Shore counties (Somerset, Wicomico, and

Worcester), MHA has held start up meetings and provided on-going support to work groups in Baltimore, St. Mary's, Harford, Washington, Frederick, Garrett, and Allegany counties and with Maryland's Department of Veterans Affairs. An increase in personnel has supported the growth of SOAR within Maryland and has resulted in a significant increase in the number of successful SSI/SSDI applications being submitted using the SOAR process. In FY 2011, through the use of PATH funding, MHA was able to fund two SOAR outreach positions, two SOAR coordinators, and a part time Data and Evaluation coordinator. These positions will continue to be funded during FY 2012.

During FY 2011 there have been 112 SOAR related SSI/SSDI claims completed. This compares with 53 claims in FY 2010. The National SOAR average in 2010 was 73% completed in an average of 91 days. During FY 2011, over 135 applications have been submitted within Maryland using the SOAR process. This is more than double the number that was submitted in FY 2010. Maryland's overall approval rate for initial claims is 86% in an average of 65 days. Baltimore City, which has submitted the most applications, has a 96% approval rate for new applications and Montgomery County has a 100% approval rate for all its SOAR applications.

MHA's Office of Special Needs Populations sponsored five, two-day Stepping Stones to Recovery SOAR trainings in collaboration with the University of Maryland Training Center using state general funding and PATH funding. These trainings took place in Baltimore City and Montgomery, Prince George's, Baltimore, and Carroll counties. The trainings provided an in-depth, step by step explanation of the SSI/SSDI application and disability determination process. Currently, there are nine active SOAR trainers within Maryland who work together to deliver the training.

During the reporting period, 204 people completed the two-day Stepping Stones to Recovery trainings which consisted of: case managers, PATH providers, human service providers and social workers. An additional 19 people participated in a one-day refresher training.

MHA has continued to expand the SOAR initiative beyond the pilot sites. MHA has trained over 200 new case managers and other homeless service providers over the past year. MHA has established state and local infrastructures to implement SOAR. It is anticipated that the focus in FY 2012 will be to strengthen those counties that are currently implementing SOAR, or who have already actively begun the planning process, as well as to explore the feasibility of extending SOAR into additional counties. In order to ensure the continuing high quality of SOAR applications, MHA is seeking to introduce a certification program in FY 2012.

Strategy Accomplishment:

This strategy was achieved.

(5-2B)

Maximize use of the Shelter Plus Care Housing funding, and other support systems to provide rental assistance to individuals with mental illnesses who are homeless, or were formerly homeless, using federal Department of Housing and Urban Development (HUD) funding.

Indicators:

- Application for funding submitted
- New funding explored under the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act and other HUD programs to expand housing and supports to prevent homelessness
- Number of families/individuals housed, services provided
- Technical assistance and trainings provided to CSAs, providers, and local continuum of care committees

Involved Parties: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations; Penny Scrivens, MHA Office of Adult Services; ADAA; CSAs; MHA facilities; Continuum of Care Homeless Boards; local service providers; consumers

MHA Monitor: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA continues to provide federal HUD funding to CSAs to provide rental assistance to individuals who are homeless or were formerly homeless. In November 2010, MHA re-applied for funding for its 19 renewal grants and in January 2011, HUD approved MHA's applications for continued funding. In previous years, MHA was renewed for 22 grants from HUD. However, in FY 2011 HUD merged grants in counties with multiple Shelter Plus Care programs. In FY 2012, MHA was awarded funding in the total amount of \$4,542,852 for the Shelter Plus Care renewal grants. The renewal grant award was slightly increased due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants.

Each local Continuum of Care of Plan must incorporate MHA's Shelter Plus Care application into its annual local plan. MHA's Shelter Plus Care Housing program is providing rental assistance to 189 families and 136 single individuals along with 312 children. Single individuals and families received rental assistance throughout scattered sites in Maryland. In addition to the housing the families received an array of supportive services through state, local, and private agencies. Services included mental health treatment, case management, alcohol and substance abuse services, health care, legal services, child care, etc.

MHA's Office of Special Needs Populations continues to: participate in local Continuum of Care Homeless Boards; provide technical assistance to providers on a daily basis via telephone, email, or written correspondence; and assist with resolving crisis situations or handling problematic situation. In addition, MHA meets with CSAs, case managers, consumers, and Shelter Plus Care monitors and providers quarterly.

The new policies as a result of the HEARTH Act were developed, published, and made available for comment in FY 2010. Planning activities for training on HEARTH by HUD began in FY 2011 and trainings, including information on funding opportunities, are scheduled for the fall of 2011.

Strategy Accomplishment:

This strategy was achieved.

GOAL VI. UTILIZE DATA AND HEALTH INFORMATION TECHNOLOGY TO EVALUATE, MONITOR, AND IMPROVE QUALITY OF PMHS SERVICES AND OUTCOMES

Objective 6.1. MHA, in collaboration with Core Service Agencies (CSAs); consumer, family and provider organizations; and state facilities will identify and promote the implementation of models of evidence-based, effective, promising, and best practices for mental health services in community programs and facilities.

(6-1A)

Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education.

Indicators:

- Annual evaluations of programs to determine eligibility for EBP rates
- Increased number of programs meeting fidelity standards for EBP programs
- Number of new programs established
- Ongoing data collection on EBPs receiving training, meeting fidelity, and providing consumer services

Involved Parties: James Chambers, Penny Scrivens, and Steve Reeder, MHA Office of Adult Services; Brian Hepburn, MHA Office of the Executive Director; Gayle Jordan-Randolph, MHA Office of the Clinical Director; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Carole Frank, MHA Office of Planning, Evaluation, and Training; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; MHTO; ASO; the University of Maryland Evidence-Based Practice (EBPC) and Systems Evaluation (SEC) Centers; CSAs; community mental health providers

MHA Monitor: James Chambers and Steve Reeder, MHA Office of Adult Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA, Mental Health Transformation Office (MHTO), and the University of Maryland's EBPC and SEC have continued to work collaboratively on consultation; training; and technical assistance related to evidence-based practice (EBP) service approaches. These include supported employment (SE), Family Psycho-education (FPE), Assertive Community Treatment (ACT), and the development of an EBP for co-occurring substance abuse disorders and mental illness. Program outcome measures and data collection methods, specific to each EBP, have been developed and implemented across all sites. EBP-specific regulations have been developed and are awaiting approval.

In August 2010, MHA's Director of Vocational Services and Evidence Based-Practices, MHA's Director of Consumer Affairs, an EBP trainer and consultant, NAMI's Family-to-Family State Coordinator, and three additional NAMI members representing four large NAMI MD affiliates, traveled to Dartmouth College for an intensive two-day training on SE. They joined representatives from seven other states already participating

in the Johnson & Johnson – Dartmouth College Community Mental Health Program, Family Advocacy Team Project. The purpose of the project is to increase awareness of SE as an EBP, among family members of persons with serious and persistent mental illness. A small stipend was provided by the project to NAMI MD to facilitate expanding SE information to families. In the remaining two years of the project, NAMI MD will receive funding to offset incurred expenses related to providing educational SE information to families.

By the end of FY 2011, representatives from 30 of the 54 SE programs have either been trained or are receiving training in the EBP model. Of the 30 programs, 21 have met fidelity standards and are eligible for the EBP rates. Also, in FY 2011, 2,903 individuals received SE services. Throughout FY 2011, MHA staff continued to provide training and technical assistance to all SE programs statewide.

Twenty-six mobile treatment (MT) programs serve adults in Maryland. In FY 2011-12, three MT programs, of the 26, are in training to become ACT teams. Twelve of the 26 programs have already met the fidelity standards for ACT and have served 2,490 adults in FY 2011. The ACT Training Resource Programs (TRPs), established under a prior SAMHSA EBP grant, continue to demonstrate competence in providing training and technical assistance under the supervision of the EBPC's ACT Trainer/Consultant. The peer consultation and training modality, wherein TRP staff train other agency staff at a similar hierarchical level, remains an effective strategy.

For Family Psycho-education (FPE), there are currently five providers who have met the fidelity standards in their provision of FPE and have served a total of 62 consumers and 78 family members in FY 2011. These providers are also offering technical assistance to sites across the state upon request and assisting ACT teams as well.

Strategy Accomplishment:

This strategy was achieved.

(6-1B)

In collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health, continue the efforts of the Maryland Child and Adolescent Mental Health Institute to explore and implement child and adolescent evidence-based practices (EBPs) and other promising practice-based models.

Indicators:

- Pilot projects with University of Maryland continued on Family-Informed Trauma Treatment employing Trauma-Informed Cognitive Behavioral Therapy models in selected sites around the state
- In collaboration with the Children's Cabinet, a range of EBPs implemented across all child-serving systems (Multi-Systemic Therapy, Functional Family Therapy)
- Wraparound fidelity in the context of the 1915(c) waiver and other interagency demonstrations monitored

Involved Parties: Al Zachik and Joan Smith, MHA Office of Child and Adolescent Services; the Children's Cabinet; Carole Frank, MHA Office of Planning, Evaluation, and Training; MSDE; University of Maryland and Johns Hopkins University Departments of Psychiatry; CSAs; CBH; Maryland Coalition of Families for Children's Mental Health; Maryland Association of Resources for Families and Youth (MARFY); MHAMD; other advocates; providers

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

The Innovations Institute at the University of Maryland, with support from the Children's Cabinet, developed and distributed quarterly data reports on two adolescent EBPs. The EBPs currently tracked are Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT). MST is provided by four separate providers in a total of eight jurisdictions and FFT is provided by four separate providers in a total of 18 jurisdictions. The funding for these two EBPs comes primarily from the Department of Juvenile Services (DJS), which tracks them as a part of its StateStat measures. DHMH is not currently a funder of these programs. Efforts have been made to include them in the Medicaid program; however, there is, at this time, a lack of adequate state match to cover these services.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) has been newly implemented in FY 2011 and the training is in various stages of completion. As of FY 2011, TF-CBT training has been conducted in Montgomery and Eastern Shore counties, Baltimore City, and for DJS staff.

Wraparound fidelity is monitored semi annually. Fidelity monitoring informs how well the Care Management Entity (CMEs) are adhering to the principles of wraparound. Fidelity is assessed through interviews with families and team members and through independent observations of wraparound team meetings. Fidelity data are shared with the CMEs, coaches, trainers, providers, and the Children's Cabinet every six months to enhance quality improvement efforts. The following results are for all wraparound participants in Maryland from July 2010-December 2010:

- The average wraparound fidelity scores are 76 (out of 100) from caregiver reports
- A score of 78 was assessed from team member reports and 79 from youth reports, suggesting that wraparound is being implemented with fidelity, as defined by the National Wraparound Initiative
- On average, 84% of youth and 79% of caregivers had an overall positive experience (i.e. “were satisfied”) with wraparound

Strategy Accomplishment:

This strategy was achieved.

(6-1C)

Establish uniform standards, practices and outcomes for the Maryland Community Criminal Justice Treatment Program (MCCJTP) and the Trauma, Addiction, Mental Health, and Recovery (TAMAR) Project and monitor the delivery of mental health and trauma-based services to individuals incarcerated in local detention centers and in the community who have a mental illness and/or substance addiction.

Indicators:

- Uniform standards, practices, and outcomes implemented
- Uniform standards achieved for TAMAR
- Technical assistance provided; monitoring implemented
- Jail diversion project established in Carroll County

Involved Parties: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations; MHA Office of Forensic Services; MHA Office of CSA Liaison; other MHA staff; CSAs

MHA Monitor: Darren McGregor, MHA Office of Special Needs Populations

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA, through the Trauma, Addictions, Mental Health, and Recovery (TAMAR) Project and the Maryland Community Criminal Justice Treatment Program (MCCJTP), continues to collaborate with local leaders of mental health and correction services to identify, assess, and provide interventions to justice-involved individuals with mental illness and substance abuse. MHA’s program development and technical assistance has helped expand services for this population in the community.

Uniform standards for MCCJTP have not been implemented, but are being researched and developed. Quarterly meetings are conducted and quarterly reports are submitted for the 22 counties participating in MCCJTP. These reports include data for the number of consumers served; data for the number of hours delivered for psychiatry, psychotherapy, and case management; and reports for selected site visits.

TAMAR provides treatment for incarcerated men and women who have histories of trauma and have been diagnosed with a mental illness and/or co-occurring substance abuse disorder. The project is available in eight county detention centers: Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Prince George’s, and Washington

counties. Additionally, there is a jail diversion program at Springfield Hospital Center in Carroll County; however, it is not monitored under MCCJTP. In FY 2011, TAMAR served nearly 500 individuals with a combination of services that included individual and group counseling, grief counseling, and case management. TAMAR standards have been developed and implemented. All jurisdictions participating in the TAMAR Project follow standardized trauma manual and established procedures; use standardized screening tools and report forms. Quarterly monitoring meetings are conducted for TAMAR. In FY 2012, it is anticipated that the TAMAR project will expand to nine jurisdictions with the addition of Harford County. Training and/or presentations on the TAMAR Project, including trauma awareness training for correctional officers at selected jurisdictions, continues to be in demand in and out of state (in places such as the New Jersey Division of Mental Health). An aggregate number of attendees for all presentations and training exceeded 500.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.2. MHA will monitor and evaluate the performance of its key contractors the administrative service organization (ASO) and the Core Service Agencies (CSAs), requiring improvement as needed.

(6-2A)

In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care for at least the same number of individuals.

Indicators:

- Contract requirements identified
- Semi-annual reporting on selected performance targets presented to MHA Management Committee and CSAs
- Information shared with key stakeholders
- Monthly and quarterly reports generated by ASO, analysis of reports by involved parties
- Analysis of utilization management practices

Involved Parties: Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; MHA Management Committee; ASO; CSAs; representatives of key stakeholder groups

MHA Monitor: Daryl Plevy, MHA Office Deputy Director for Community Programs and Managed Care

FY 2011 activities and status as of 6/30/2011 (end-year report):

MHA has continued to serve individuals of all ages with mental illnesses, even as it has assumed fiscal and administrative responsibility for mental health care for the total Medicaid population under the MA 1115 waiver. In FY 1999 (first year of available data), more than 68,000 individuals were served. Sixty-three percent were adults and 37

percent were children and adolescents. Fifty-two percent met the diagnostic criteria for serious mental illness (SMI) and 72 percent met the criteria for serious emotional disorder (SED). Over the last twelve years, the number served has grown to more than 133,956 individuals who had claims submitted for mental health services through the fee-for-service system. Of the total, 81,799 are adults, sixty-one percent (61%), and 52,157, thirty-nine percent (39%), are children and adolescents. More than sixty-four percent (64.5%) of adults served were individuals with SMI. More than seventy-four percent (74.8%) of the children and adolescents served were individuals with SED.

Strategy Accomplishment:

This strategy was achieved.

(6-2B)

Review, in collaboration with the ASO and CSAs, providers' clinical utilization, billing practices, and compliance with regulations.

Indicators:

- Number of audits conducted
- Audit reports and compliance activities reviewed
- Corrective actions identified/implemented as needed

Involved Parties: Audrey B. Chase, MHA Office of Compliance; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; James Chambers, MHA Office of Adult Services; Al Zachik, MHA Office of Child and Adolescent Services; DHMH OHCQ; ASO; CSAs

MHA Monitor: Audrey B. Chase, MHA Office of Compliance

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2011, MHA's Office of Compliance worked with the administrative services organization (ASO) to ensure the completion of 63 outpatient program audits and seven inpatient program audits. All audits were conducted as retrospective reviews of services provided. Provider entities included psychiatric rehabilitation programs (PRPs), outpatient mental health clinics, residential treatment centers, and hospitals. In all instances, audit findings were presented in a formal audit report and, as required, corrective actions were identified and implemented through scheduled retractions and/or an approved Performance Improvement Plan. MHA's Office of Compliance continues to work with the Office of the Inspector General to prevent fraud and abuse as well as identify opportunities for further investigation and recovery.

Strategy Accomplishment:

This strategy was achieved.

(6-2C)

Review and approve CSA mental health plans, budget documents, annual reports, and letters of review from local mental health advisory committees (LMHACs) and CSA advisory boards.

Indicators:

- Plans submitted from each CSA
- Compliance with MHA planning guidelines for CSA Plans evaluated
- Letters of review and recommendation received from each LMHAC and/or CSA board
- Previous fiscal year annual reports received
- MHA letter of review sent

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Cynthia Petion, MHA Office of Planning, Evaluation, and Training; Alice Hegner, MHA Office of CSA Liaison; MHA Office of Administration and Finance; MHA Review Committee (includes representatives of all major MHA offices); CSAs; LMHACs; CSA advisory boards

MHA Monitor: Cynthia Petion, MHA Office of Planning, Evaluation, and Training

FY 2011 activities and status as of 6/30/2011 (end-year report):

Each year an extensive plan development process is implemented, beginning in January, with the submission, to the MHA, of local mental health plans and budgets from the Core Service Agencies (CSAs). The CSA Plan and Budget guidelines are developed through MHA's Office of Planning, Evaluation, and Training to guide the development of local plans that identify priorities, strengths, needs and service gaps of the local public mental health system as well as a description of stakeholder input. An official comprehensive Plan is submitted by each CSA every three years with updated documents developed and submitted during the two years in between. To simplify data submissions, each CSA continued to include standardized data templates in its submission.

In FY 2011, The CSAs' FY 2012-2014 Mental Health Plan and Budget documents were submitted to MHA and reviewed by a committee consisting of 12-15 MHA staff. Documents were submitted in the formats of either three-year plans or first or second year plan updates so that all CSA Plan submissions are scheduled on a continuum rather than have the MHA review staff review all comprehensive plans at one time. Each plan included, as required, a letter of review with recommendations from the local mental health advisory committee of that jurisdiction or documentation of review from the CSA Board of Directors.

CSAs were also required to submit their fiscal year 2010 Annual Reports. As of FY 2008 the CSAs have been submitting the annual report documents electronically. The plans and annual reports included discussions of the CSAs' achievements, interagency collaborations and partnerships, local and statewide initiatives, and financial plans linked to mental health services. Three-year plans included needs assessments, the findings from which were linked to goals and strategies. All plans were found to be in compliance with MHA's Guidelines Regarding Fiscal Year 2012-2014 Plans/Budgets.

Strategy Accomplishment:

This strategy was achieved.

(6-2D)

Monitor and collect documentation on each CSA's performance of activities, as outlined in the Memorandum of Understanding (MOU), on risk-based assessment of the CSA and specific MOU elements; and notify the appropriate MHA program director of exceptions that may require corrective action or additional technical assistance.

Indicators:

- Monitoring tools utilized
- Self-reports from CSAs monitored
- CSA program improvement plans reviewed
- On-site assessment of CSAs conducted
- Monitoring reports summarized

Involved Parties: Alice Hegner, MHA Office of CSA Liaison; CSAs; appropriate MHA staff

MHA Monitor: Alice Hegner, MHA Office of CSA Liaison

FY 2011 activities and status as of 6/30/2011 (end-year report):

The MHA Office of CSA Liaison conducted three quarterly monitorings in a combination of on-site and/or conference calls for all 19 CSAs for compliance with the MOU for FY 2011. Monitoring for each CSA's administration and for its subvendors, included:

- Review of the use of both state general funds and federal block grant dollars
- Report from each of the 19 CSAs submitted regarding the timely execution of their subvendor contracts
- Type of contract used
- Requirement for an audit, its due date, copy of audit review
- Administrative reports on selected elements of the MOU, and a fiscal update for year-to-date expenditures
- Performance measures with projections for the fiscal year for the CSA's administration and subvendors
- Review of the use of Consumer Support funds
- Summaries of a questionnaire regarding certain administrative components of the MOU

In addition, a selected sample of subvenders' contracts at each CSA was reviewed, including the contract, budget for cost reimbursement, programmatic report from the subvendor, invoice, payment, audit if required, documentation of the CSA's review of the audit, site visit by the CSA, and internal controls by the CSA.

Of the 19 CSAs, eighteen consistently implemented their subvenders' contracts in a timely manner and did oversee the expenditure of state general funds and federal mental health block grants in accordance with the requirements and duties as contained in the MOU. The nineteenth CSA is within a county agency which follows its jurisdiction's procurement protocols and timeframes more closely than MHA's.

The Office of CSA Liaison prepares three quarterly reports for MHA's Deputy Director for Community Programs and Managed Care, noting particular issues such as specific information and data aggregated from MHA monitoring regarding subvendor contracts, requirements for audits, site visits, internal controls at the CSAs, and congruence with the Conditions of Award in the MOU between the MHA and the CSA. MHA retains the documentation provided by the CSAs on file, providing both verbal feedback through scheduled conference calls and documentation of its findings for each CSA, copied to the MHA Management Committee and available for review in the MHA Office of CSA Liaison.

Strategy Accomplishment:

This strategy was achieved.

(6-2E)

Review MHA's budget and PMHS expenditures and services; implement corrective actions, as needed, to maintain operations within allocation.

Indicators:

- Quarterly expenditure management plans developed and reviewed
- Regular meetings with MHA facility chief executive officers (CEOs) held
- Expenditures and needs reviewed by clinical directors and financial officers

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Randolph Price, MHA Office of Administration and Finance; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Facility CEOs; DHMH Headquarters; clinical directors and financial officers

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Randolph Price, MHA Office of Administration and Finance

FY 2011 activities and status as of 6/30/2011 (end-year report):

Following the installation of the new ASO in September, 2009, MHA and the ASO have reviewed weekly and quarterly expenditure and utilization reports to ascertain trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, and correcting any problems that may be identified. Additionally, the CSAs routinely review various Crystal

Reports detailing claims and utilization for consumers and providers within their respective counties.

The current economic crisis has had a significant impact on the State of Maryland. With declining state revenues and increasing demands for services, the state budget and the PMHS have been challenged. In FY 2011, numerous budget meetings/reviews were conducted involving MHA Headquarters, Facilities, and DHMH personnel. Operations were adversely impacted by funding constraints compounded by increased enrollment of MA eligible consumers.

Although there was insufficient funding at year-end, other efforts continue to be monitored in the PMHS including the review of individuals who are uninsured to determine if applicable entitlement benefits have been received. This includes the Primary Adult Care (PAC) program. Uninsured individuals enrolled in the PAC now have Medical Assistance (MA) coverage for most mental health care (excluding hospital emergency room service, inpatient, and outpatient hospital-based services).

Another significant result of the current budget processes is a long-term, ongoing trend to promote less costly community-based services while continuing to meet the expanding demand for PMHS services. These efforts result in a lower average cost per individual consumer served and is reflected in the various utilization data reports monitored by MHA and the CSAs.

Strategy Accomplishment:

This strategy was partially achieved.

Objective 6.3. MHA, in collaboration with CSAs, state facilities, the administrative services organization (ASO), and key stakeholders, will utilize data and technology, through a variety of approaches, to evaluate and improve the appropriateness, quality efficiency, cost effectiveness, and outcomes of mental health services within the PMHS.

(6-3A)

Continue to monitor the implementation of the Outcomes Measurement System (OMS), including completion of the transition of multiple, complex aspects of this initiative to the new ASO.

Indicators:

- Implementation of OMS monitoring reporting and feedback mechanisms tasks reestablished, including OMS expenditure analysis
- Review of provider utilization rates, and review of provider questionnaire completion rates; resolution of identified problems
- Interactive OMS Web-based system reestablished with refinements; continued development of analytical structures, displays, and reports that measure and reflect change-over-time analyses at the state, CSA, and provider levels

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; Sheba Jeyachandran, MHA consultant; MHA Management Committee; ASO; CSAs; SEC; CBH; providers; consumer, family, and advocacy groups

MHA Monitor: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs

FY 2011 activities and status as of 6/30/2011 (end-year report):

In FY 2011, work was underway on development of the complex and detailed functional and technical specifications required to reestablish the OMS Datamart. This has been a collaborative effort involving staff from MHA, the University of Maryland Systems Evaluation Center (SEC), and the ASO.

Many complex issues have been encountered and systematically addressed during the specification development process. These included combining OMS data from the previous ASO vendor with OMS data from the current ASO, finalizing analytical structures to calculate outcome results, identifying episodes of care at the client and provider levels, incorporating new OMS items into the analysis, designing the actual Datamart display templates, developing the programming needed to support the project and display OMS results, etc. While, due to the complexity of the project, the OMS Datamart is not yet operational, it is anticipated that it will be functioning by the end of the calendar year.

A meeting between MHA and ASO staff to identify/discuss the parameters for the OMS monitoring reports was held. While, due to competing priorities, development of those reports has not yet been completed, it is also expected that this will occur prior to the end of the calendar year.

Strategy Accomplishment:

This strategy was partially achieved.

(6-3B)

Continue the annual statewide client perception of care surveys of adults and parents/caretakers of children and youth regarding their experiences with PMHS services.

Indicators:

- Data analysis of FY 2010 survey results completed
- Percentage of adult consumers who report that they deal more effectively with daily problems and percentage of parents/caretakers who report that their child is better able to control his/her behavior (percentages based on respondents who agree and strongly agree) included in MHA's Managing for Results (MFR) submission
- FY 2011 survey conducted

Involved Parties: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs; Cynthia Petion, MHA Office of Planning, Evaluation, and Training; Randolph Price, MHA Office of Administration and Finance; ASO

MHA Monitor: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs

FY 2011 activities and status as of 6/30/2011 (end-year report):

Data analysis of the FY 2010 Consumer Perception of Care (CPOC) survey results was completed. A detailed survey report, an executive summary report, and trifold brochures were finalized and disseminated in January 2011. Selected results of the CPOC surveys continue to be incorporated into MHA's MFR budget submission process and the required annual reporting in the Federal Block Grant Uniform Reporting System (URS) tables. The FY 2011 CPOC survey was also conducted.

Strategy Accomplishment:

This strategy was achieved.

(6-3C)

Enhance capacity for stakeholders to utilize PMHS data to measure service effectiveness and outcomes.

Indicators:

- Access to data increased to develop standard and ad hoc reports
- Input gathered from stakeholders on the practicality and efficacy of reports; technical assistance and regional trainings held as necessary
- Reports generated, public domain Web site launched making PMHS demographic data available to users outside of state agencies
- Data liaison between MHA and CSAs created to evaluate current data system and data reports used for the purpose of policy and planning by CSAs and other stakeholders

Involved Parties: Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Cynthia Petion, MHA Office of Planning, Evaluation, and Training; MHA Management Committee; ASO; SEC; CSAs; the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council; provider, consumer, family, and advocacy groups

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2011 activities and status as of 06/30/11 (end-year report):

FY 2010 was a transition year between the former ASO - MAPS-MD - and current contract holder-Value Options® Maryland (VO). FY 2011 was used as a time of data validation and report refinement. Efforts were maintained to provide PMHS data to all stakeholders. Priority shifts during first year with the new vendor delayed the re-launching of the public domain. However, PMHS quarterly reports were published for public consumption on the administration's Web site www.dhmd.state.md.us/mha. With VO, the current ASO, MHA created standardized policy to request the development of ad hoc reports utilizing the PMHS data. Also, there were extended efforts for the first time to allow for the request of county-specific raw data sets to promote the analysis and use of PMHS data to coordinate planning efforts. Additionally, technical assistance in data usage opportunities was expanded to the public and stakeholders outside of the MHA through the Systems Evaluation Center (SEC).

Quarterly trainings were conducted to instruct MHA, CSA, and SEC staff on how to access PMHS data through VO's Intelligence Connect Web site, utilizing Crystal reports. In efforts to further the PMHS system and the access of data to all stakeholders, the MHA Office of Management Information Systems (MIS) heads two monthly data-centered meetings. Representatives from MHA's MIS office and the Office of Planning, Evaluation, and Training are present, as well as ASO, SEC and CSA members. The monthly meetings are used as a vehicle to filter data specific information to all interested stakeholders, review and approve standard reports, and allow committee members the opportunity to make suggestions for the overall enhancement of the PMHS data system.

Also, the MIS Office is represented at the monthly meeting of the Maryland Association of Core Service Agencies (MACSA) to update committee members of current and future projects affecting the PMHS data system. A key function of the committee is to create CSA-specific reports that aid the agencies to track service utilization, provider usage, and expenditure data. In this current fiscal year, three ad hoc reports requested by a specific CSA evolved into a standardized data report made available to all 19 CSAs. Having the detailed data readily available has helped the CSAs track cost, service utilization, and management of Medicaid reimbursements.

Strategy Accomplishment:

This strategy was achieved.

(6-3D)

Monitor the delivery of forensic services and generate statistical information to inform policy and promote public awareness; analyze the impact of community-based forensic evaluations on hospital admission rates and lengths of stay for court-ordered individuals.

Indicators:

- Program evaluator hired
- Number and results of court-ordered evaluations, the number and percentage of individuals in DHMH facilities on court order, and the number and success of consumers on court-ordered conditional release in the community
- Reports submitted to MHA Management Committee, the CSAs, and the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council

Involved Parties: Larry Fitch and staff, MHA Office of Forensic Services; Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; MHA facilities; Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council; CSAs

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

FY 2011 activities and status as of 6/30/2011 (end-year report):

Ongoing monitoring of more than 750 consumers on pre-trial and conditional release continued in FY 2011, including reports to the State's Attorney, as appropriate. A Program Evaluator was hired but did not remain in the position for long. Subsequently, it was decided that it was more effective to enhance forensic services contracting through Harford County. MHA's OFS staff, in collaboration with the CSAs, collected data and outcomes for approximately 1,200 adult community-based court-ordered pre-trial evaluations, 115 presentence psychiatric evaluations, 40 presentence sex offender evaluations, and 120 juvenile court competency to proceed evaluations. These results were reported in FY 2011 to assist the CSAs and other PMHS leadership in planning efforts. It has been noted that the arrest rate for people on conditional release from a MHA facility, after being found not criminally responsible (NCR), was less than three percent, which is lower than the arrest rate for the general population (about 4.4%).

The Co-Chairs of the Interagency Forensic Services Committee (IFSC) gave an informative overview of the work of MHA and the IFSC, along with notable statistics, to the Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council (also known as the Joint Council) on September 21, 2010. Committee reports and proceedings continue to be submitted regularly to MHA and the Joint Council.

Strategy Accomplishment:

This strategy was achieved.

Objective 6.4. MHA, in collaboration with CSAs, the ASO, and key stakeholders, will promote the use of technology as a tool to improve information sharing, data collection, training, evaluation and performance, and outcomes.

(6-4A)

Enhance PMHS data collection and monitoring through continued activities to develop and/or refine management information systems.

Indicators:

- Technical aspects of management information systems refined, logic of reports enhanced to reflect recovery orientation and efficient use of service data, accuracy and usefulness of current reports identified
- Promotion of Web-based OMS datamart for access to point-in-time and change-over-time information continued
- Data utilized to enhance the Joint Commission submissions
- Additional funding explored to sustain development and implementation

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Sharon Ohlhaber, MHA Office of Quality Management and Community Program; Cynthia Petion, MHA Office of Planning, Evaluation, and Training; SEC; DHMH's Information Resource Management Administration (IRMA); MA; CSAs; ASO; providers

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

FY 2011 activities and status as of 06/30/2011 (end-year report):

The transition to a new ASO, during the previous fiscal year, has afforded MHA the opportunity to "fine tune" its past data reports. As the various data committees met throughout the current year they continued to critique and make recommendations to complete the assessment of all data reports.

Monthly data and information technology conference calls with the current ASO are conducted to ensure proper execution of logic behind data reports and that all business rules are predefined. Reporting systems are being fine tuned to promote ease of use. Bi-monthly meetings are held to discuss data reports, conduct trainings to help with accessing data system, enhance the utilization of the data for trending and analysis, and to trouble shoot existing reports. DHMH continues to submit monthly hospital management

information system data to NASMHPD Research Institute (NRI) who shares the information with the Joint Commission to use as a part of its accreditation reviews.

In FY 2011, work was underway on development of the complex and detailed functional and technical specifications required to reestablish the OMS Datamart. This has been a collaborative effort involving staff from MHA, the University of Maryland Systems Evaluation Center (SEC), and the ASO. For further details see strategy 6-3A above.

During this time of fiscal crisis, no alternate funding streams have been identified to supplement or replace existing data systems.

Strategy Accomplishment:

This strategy was partially achieved.

(6-4B)

Maintain accreditation of MHA facilities by the Joint Commission.

Indicator:

- All MHA facilities accredited

Involved Parties: Brian Hepburn, MHA Office of the Executive Director; Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; Gayle Jordan-Randolph, MHA Office of the Clinical Director; MHA Management Committee; MHA Facility CEOs; appropriate facility staff

MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations

FY 2011 activities and status as of 6/30/2011 (end-year report):

All MHA facilities have maintained their Joint Commission accreditation status. The state psychiatric facilities are significant participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland. Staff at each of the facilities participate in regular trainings to keep current with changes in Joint Commission standards and are involved in the accreditation evaluation. The evaluators interview random employees to ensure that the staff is knowledgeable about the mission, vision and policies of each facility. The evaluators review all patient care processes and, depending on the size of the facility, can take up to five days to complete the evaluation process.

MHA Management Committee and facility administration will continue the monitoring of continuous quality improvement initiatives.

Strategy Accomplishment:

This strategy was achieved.

(6-4C)

MHA, in collaboration with the Developmental Disabilities Administration (DDA), will provide access to and train appropriate MHA and DDA staff in the use of the hospital management information system (HMIS) and the Provider Consumer Information System 2 (PCIS2) data systems to better serve individuals with co-occurring diagnoses in MHA facilities and in the community.

Indicators:

- Programming changes made to HMIS
- MHA and DDA staff identified and trained in HMIS and PCIS2 systems
- Increased eligibility for discharge, expedient discharge process
- Collaboration facilitated among leadership at MHA and DDA, regional offices, and CSAs

Involved Parties: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations; MHA Office of Consumer Affairs; Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care; Stefani O'Dea, MHA Office of Adult Services; Renata Henry, DHMH Deputy Secretary for Behavioral Health and Disabilities; Lisa Hovermale, DHMH Liaison MHA/DDA; Susan Bradley, MHA Office of Management Information Systems and Data Analysis; Tom Booker, DHMH IRMA; Diane Bolger, DDA; Maryland Association of Core Service Agencies (MACSA); CSAs; Facilities' CEOs

MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations and Daryl Plevy, MHA Office of the Deputy Director for Community Programs and Managed Care

FY 2011 activities and status as of 6/30/2011 (end-year report):

The hospital management information system (HMIS) is being revised to accommodate a report format that will help both MHA and DDA staff track individuals with co-occurring diagnosis and their eligibility. The joint database has been developed and meetings have been held to further refine HMIS fields. Collaboration between MHA and DDA continues and it is expected that the reporting format will be finalized and training will be developed and implemented into the next fiscal year. The staff who are to be trained have been identified. Appropriate staff will receive access to and training in HMIS and PCIS2 to enable them to conduct queries of the data bases to facilitate eligibility and discharge processes.

Strategy Accomplishment:

This strategy was partially achieved.

Appendix

Acronyms

| | |
|---------------|---|
| ACT | Assertive Community Treatment |
| ADAA | Alcohol and Drug Abuse Administration |
| ARRA | American Recovery and Reinvestment Act |
| ASO | Administrative Services Organization |
| CBH | Community Behavioral Health Association of Maryland |
| CEO | Chief Executive Officers |
| CCISC | Comprehensive, Continuous, Integrated System of Care |
| CEU | Continuing Education Units |
| CHIPRA | Children’s Health Insurance Program Reauthorization Act |
| CILS | Centers for Independent Living |
| CLCTI | Cultural and Linguistic Competence Training Initiative |
| CME | Care Management Entity |
| CMS | Center for Medicare/Medicaid Services |
| COOP | Continuity of Operations Plan |
| CSA | Core Service Agency |
| CSEFEL | Center on the Social and Emotional Foundations for Early Learning |
| CQT | Consumer Quality Team |
| DDA | Developmental Disabilities Administration |
| DDC | Dual Diagnosis Capability |
| DHCD | Maryland Department of Housing and Community Development |

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| DHMH | Maryland Department of Health and Mental Hygiene |
| DHR | Maryland Department of Human Resources |
| DJS | Maryland Department of Juvenile Services |
| DORS | Division of Rehabilitation Services |
| DPSCS | Department of Public Safety and Correctional Services |
| DSS | Department of Social Services |
| EBP | Evidence-Based Practice |
| EBPC | Evidence-Based Practice Center |
| EID | Employed Individuals with Disabilities |
| EMTALA | Emergency Medical Treatment and Labor Act |
| FEMA | Federal Emergency Management Administration |
| FFT | Functional Family Therapy |
| FHA | Family Health Administration |
| FPE | Family Psycho-education |
| GOC | Governor's Office for Children |
| HB | House Bill |
| HCRCC | Maryland Health Care Reform Coordinating Council |
| HMIS | Hospital Management Information System |
| HSCRC | Health Services Cost Review Commission |
| HTI | The Healthy Transitions Initiative |
| HUD | Housing and Urban Development |
| ICS | Incident Command System |
| IDEHA | Infectious Diseases and Environmental Health Administration |

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| IFSC | Interagency Forensic Services Committee |
| IMD | Institutes of Mental Disease |
| IRMA | Information Resource Management Administration |
| LEAP | Leadership Empowerment and Advocacy Project |
| LGBTQ | lesbian, gay, bisexual, transgender, or questioning |
| LMB | Local Management Boards |
| LMHAC | Local Mental Health Advisory Committee |
| MA | Medical Assistance or Medicaid |
| MACSA | Maryland Association of Core Service Agencies |
| MAPSS | Maryland Association of Peer Support Specialists |
| MARFY | Maryland Association of Resources for Families and Youth |
| MART | Multi-Agency Review Team |
| MCCJTP | Maryland Community Criminal Justice Treatment Program |
| MCF | Maryland Coalition of Families for Children's Mental Health's |
| MCLC | Maryland Consumer Leadership Coalition |
| MCO | Managed Care Organization |
| MDLC | Maryland Disability Law Center |
| MDoA | Maryland Department of Aging |
| MDOD | Maryland Department of Disabilities |
| MEMA | Maryland Emergency Management Administration |
| MFP | Money Follows the Person |
| MFR | Managing for Results |
| MHA | Mental Hygiene Administration |

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| MHAMD | Mental Health Association of Maryland, Inc. |
| MHCC | Maryland Health Care Commission |
| MHCJP | Mental Health & Criminal Justice Partnership |
| MMHEN | Maryland Mental Health Employment Network |
| MHFA | Mental Health First Aid |
| MHT-SIG | Mental Health Transformation State Incentive Grant |
| MHTO | Mental Health Transformation Office |
| MI | Motivational interviewing |
| MNG | Maryland National Guard |
| MOU | Memorandum of Understanding |
| MSDE | Maryland State Department of Education |
| MST | Multi-Systemic Therapy |
| MT | Mobile Treatment |
| NAMI MD | National Alliance for Mental Illness-Maryland |
| NASMHPD | National Association of State Mental Program Directors |
| NIMS | National Incident Management System |
| NOC | Maryland Network of Care |
| NOFA | Notice of Funds Availability |
| OCA | Office of Consumer Affairs |
| ODHH | Governor's Office of the Deaf and Hard of Hearing |
| OFS | Office of Forensic Services |
| OHCQ | Office of Health Care Quality |
| OMHC | Outpatient Mental Health Clinic |

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|---------------|--|
| OMS | Outcome Measurement System |
| OOOMD | On Our Own of Maryland, Inc. |
| PAC | Primary Adult Care |
| PATH | Projects for Assistance in Transition from Homelessness |
| PCC | Person Centered Care |
| PCIS2 | Provider Consumer Information System 2 |
| PERS | Peer Employment Resource Specialist |
| PHA | Local Public Housing Authorities |
| PHTSY | Psychiatric Hospitalization Tracking System for Youth |
| PMHS | Public Mental Health System |
| PRP | Psychiatric Rehabilitation Program |
| PRTF | Psychiatric Residential Treatment Facility |
| PTSD | Post-Traumatic Stress Disorder |
| RRP | Residential Rehabilitation Program |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SCYFIS | State Children, Youth and Family Information System |
| SDC | Self-Directed Care |
| SE | Supported Employment |
| SEC | Systems Evaluation Center |
| SED | Serious Emotional Disorders |
| SMI | Serious Mental Illness |
| SOAR | Supplemental Social Security, Outreach, Access, and Recovery |
| SOC | System of Care |

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|-------------------|--|
| SSA | Social Security Administration |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |
| TAC | Technical Assistance Collaborative, Inc. |
| TAMAR | Trauma, Addiction, Mental Health, and Recovery |
| TAY | Transition-Age Youth |
| TBI | Traumatic Brain Injury |
| TTW | Ticket-To-Work |
| UMBC | University of Maryland – Baltimore County |
| WRAP | Wellness Recovery Action Plan |
| Youth MOVE | Youth Motivating Others through Voices of Experience |